

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH *St. George* 5666 (28) 54  
 County *Laurel*  
 Village or City *Laurel* (No. *54*) St. *54* Ward *54*  
 2 FULL NAME *Virginia Georgia Ashby* [It death occurred in a hospital or institution, give its NAME instead of street and number.]  
 Registration Dist. No. *239*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Widow*  
 6 DATE OF BIRTH *Jan. 4<sup>th</sup>*, 1852 (Month) (Day) (Year)  
 7 AGE *63* yrs. *3* mos. *21* ds. If LESS than 1 day, .... hrs. OR .... min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work. *None*  
 (b) General nature of industry, business, or establishment in which employed (or employer) *None*

9 BIRTHPLACE (State or country) *Virginia*  
 10 NAME OF FATHER *Geo. Herndon*  
 11 BIRTHPLACE OF FATHER (State or country) *Virginia*  
 12 MAIDEN NAME OF MOTHER *Mary Keys*  
 13 BIRTHPLACE OF MOTHER (State or country) *Virginia*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) *Mrs. Estie B. Waters*  
 (Address) *Laurel Md.*

15 Filed *Apr. 27<sup>th</sup>*, 1915 *Wm. A. Fairall*  
 REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *April 23<sup>rd</sup>*, 1915 (Month) (Day) (Year)  
 17 I HEREBY CERTIFY, That I attended deceased from *Mar. 24<sup>th</sup>*, 1915, to *April 20<sup>th</sup>*, 1915, that I last saw her alive on *April 24<sup>th</sup>*, 1915, and that death occurred on the date stated above, at *7 A.* m.  
 The CAUSE OF DEATH\* was as follows:

*With drawn formalin open*  
*Suddenly* (Duration) yrs. .... mos. *8* ds.  
 Contributory *Tuberculosis*  
 Secondary (Duration) yrs. .... mos. .... ds.

(Signed) *J. R. Pugh*, M. D.  
*April 26<sup>th</sup>*, 1915 (Address) *Laurel Md.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
 At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.  
 Where was disease contracted, If not at place of death?  
 Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Joy Hill* DATE OF BURIAL *April 27<sup>th</sup>*, 1915  
 20 UNDERTAKER *Rev E. French* ADDRESS *Laurel Md.*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scutle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tiraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—dece-dent*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 5 1915  
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

|   |   |  |  |   |  |
|---|---|--|--|---|--|
| 1 PLACE OF DEATH<br>County <u>Prince George</u>   |   | 5657   |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH   |  |
| Village or City <u>Rigg's Mill</u> (No. <u>180</u> )  |   | Registration Dist. No. <u>3015</u>   |  | [If death occurred in a hospital or institution, give its NAME instead of street and number.] |  |
| 2 FULL NAME <u>Andrew Bailey</u>  |   |  |  |   |  |
| PERSONAL AND STATISTICAL PARTICULARS  |   |  |  |   |  |
| 3 SEX<br><u>Male</u>  | 4 COLOR OR RACE<br><u>White</u>                       | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>Married</u> |  |   |  |
| 6 DATE OF BIRTH<br><u>3</u> <u>5</u> , 18 <u>49</u><br>(Month) (Day) (Year)   |   |  |  |   |  |
| 7 AGE<br><u>66</u> yrs. <u>1</u> mos. <u>24</u> ds. OR <u>1</u> day, <u>24</u> hrs. If LESS than 1 day, <u>24</u> hrs.  |   |  |  |   |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>Farmer</u><br>(b) General nature of industry, business, or establishment in which employed (or employer)   |   |  |  |   |  |
| 9 BIRTHPLACE (State or country) <u>md.</u>  |   |  |  |   |  |
| PARENTS   | 10 NAME OF FATHER <u>Geo. R. Bailey</u>               |  |  |   |  |
|   | 11 BIRTHPLACE OF FATHER (State or country) <u>md.</u> |  |  |   |  |
|   | 12 MAIDEN NAME OF MOTHER <u>Eliza Norton</u>          |  |  |   |  |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>md.</u>   |   |  |  |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Mrs. Andrew Bailey</u><br>(Address) <u>Hyattsville</u>   |   |  |  |   |  |
| 15 Filed <u>April 28, 1915</u> <u>Mrs. Jas. Severe</u> REGISTRAR  |   |  |  |   |  |
| MEDICAL CERTIFICATE OF DEATH  |   |  |  |   |  |
| 16 DATE OF DEATH <u>4</u> <u>27</u> , 191 <u>5</u><br>(Month) (Day) (Year)  |   |  |  |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>191</u> to <u>191</u> , that I last saw him <u>alive on</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>6:30</u> p.m.  |   |  |  |   |  |
| The CAUSE OF DEATH* was as follows:<br><u>This death was caused by lightning - was killed instantly</u>   |   |  |  |   |  |
| (Duration) <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds.   |   |  |  |   |  |
| Contributory<br>Secondary   |   |  |  |   |  |
| (Duration) <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds.   |   |  |  |   |  |
| (Signed) <u>th St. J. Brown</u> , M. D.<br><u>Apr 27, 1915</u> (Address) <u>Silver Spring</u>   |   |  |  |   |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.   |   |  |  |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds.<br>Where was disease contracted, If not at place of death?<br>Former or usual residence |   |  |  |   |  |
| 19 PLACE OF BURIAL OR REMOVAL <u>Rock Creek D.C.</u> DATE OF BURIAL <u>Apr 29, 1915</u>   |   |  |  |   |  |
| 20 UNDERTAKER <u>Gasch's Sons</u> ADDRESS <u>Hyattsville</u>  |   |  |  |   |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-kenital" "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inauition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAY 4 1915

BUREAU, V.S.



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## 1 PLACE OF DEATH

County Pr GeoVillage or City Croom (No. 120) St.; WardSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 233

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Cornelia Barnes

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Unknown, 1847  
(Month) (Day) (Year)

7 AGE 68 yrs. Unknown mos. Unknown ds. OR LESS than 1 day.....hrs. OR.....min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md.

PARENTS  
10 NAME OF FATHER John Calbert  
11 BIRTHPLACE OF FATHER (State or country) Md.  
12 MAIDEN NAME OF MOTHER Cornelia Jackson  
13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. H. Chees  
(Address) Croom Md

15 Filed April 20, 1915 Ernest H. Garner  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 17, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1915 to April 17, 1915.

that I last saw him alive on April 17, 1915

and that death occurred on the date stated above, at 8 P m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis  
(Duration) ..... yrs. .... mos. .... ds.

Contributory  
Secondary

(Signed) W. H. Gibbons, M. D.  
April 19, 1915 (Address) Croom Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St James Croom Md DATE OF BURIAL April 21, 1915

20 UNDERTAKER Stamps Bros ADDRESS Waltham

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*; *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicaemia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAY 4 1915

BUREAU, U.S.

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## 1 PLACE OF DEATH

County

Pr. Esco

Village or City

Freestville

(No. \_\_\_\_\_)

St.; \_\_\_\_\_ Ward)

Registration Dist. No. 235

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Bayne

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Wh

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Apr 30, 1915  
(Month) (Day) (Year)

7 AGE

Premature Birth If LESS than 1 day, \_\_\_\_ hrs. \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. OR \_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md.

10 NAME OF FATHER

John W. Bayne

11 BIRTHPLACE OF FATHER

Md.

12 MAIDEN NAME OF MOTHER

Minnie Sabersick

13 BIRTHPLACE OF MOTHER

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John W. Bayne

(Address)

Freestville

15

Filed

191

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Apr 30, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

\_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw him alive on \_\_\_\_\_, 191\_\_\_\_,

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Premature Birth  
Gestation 6 mos.Contributory  
Secondary(Signed) John C. Lawrence, M. D.  
Apr 30, 1915 (Address) Freestville

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State, \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Print engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reckless wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*; *tidanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

B. Geo

Village or City

TB

(No.)

St.

Ward)

Registration Dist. No.

240

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Lurelyn Beall

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

May 13, 1905

7 AGE

9 yrs. 11 mos. 9 ds.

It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md

## PARENTS

10 NAME OF FATHER

Wm Beall

11 BIRTHPLACE OF FATHER (State or country)

Md

12 MAIDEN NAME OF MOTHER

Mary Tolson

13 BIRTHPLACE OF MOTHER (State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Philly Beall

(Address)

Brandysville Md

15

Filed

Apr. 22nd, 1915

J. K. Smith

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 22, 1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I ~~attended~~ <sup>attended</sup> deceased from

Apr. 21, 1915 to Apr. 21, 1915

that I last saw him alive on Apr. 21, 1915

and that death occurred on the date stated above, at 6-30 a. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia Lobar

(Duration) yrs. mos. 10 ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

John A. Coz

M. D.

Apr. 22, 1915 (Address) Brandysville Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Union Bethel, T. B. Md.

Apr. 23rd, 1915

20 UNDERTAKER

ADDRESS

Huntt &amp; Ryan, Waldorf Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) infection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 5 1915

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Buena VistaVillage or City Laurel

(No. \_\_\_\_\_)

St.; \_\_\_\_\_

Ward \_\_\_\_\_

Registration Dist. No. 239

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Brehm

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Wid.

6 DATE OF BIRTH Oct. 10th 1831  
Apr. 3, 1915  
(Month) (Day) (Year)

7 AGE 83 yrs. 5 mos. 28 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work None  
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Thomas J. Hall

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Rachel S. Waters

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Waters Brehm(Address) New York City

15 Filed Apr. 5th, 1915 Wm. A. Fairall

REGISTRAR

5611

103

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr. 3, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mar 30, 1915, to Apr 3, 1915, that I last saw her alive on Apr 3, 1915, and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH \* was as follows:

Acute indigestion(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 4 ds.Contributory Eclampsia

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) W. H. Taylor, M. D.  
Apr 4, 1915 (Address) Laurel Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State, \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

When was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Balto Md DATE OF BURIAL Apr 6, 1915

20 UNDERTAKER Geo E. Lusk ADDRESS Laurel Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *men-*

*ges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic reticular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trachia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

MAY 5 1915

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County

Pr Geo

56/2

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

240

Village or City

Brandywine

(No.)

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

William L Bryan

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

married

6 DATE OF BIRTH

April 7

(Day)

1876  
(Year)

7 AGE

39

yrs.

mos.

16

ds.

If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Teamster

9 BIRTHPLACE

(State or country)

Md

## PARENTS

10 NAME OF  
FATHER

Sumner Bryan

11 BIRTHPLACE  
OF FATHER  
(State or country)

Md

12 MAIDEN NAME  
OF MOTHER

Margaret E Bryan

13 BIRTHPLACE  
OF MOTHER  
(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ida Bryan

(Address)

Brandywine Md

15

Filed

Apr. 24<sup>th</sup> 1915

J. R. Smith

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 23

1915  
(Year)

17

I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him alive on April 23, 1915

and that death occurred on the date stated above, at 12 m.

The CAUSE OF DEATH\* was as follows:

Died suddenly in phys-  
ician's office after  
supper from alcohol  
intoxication (Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

W. H. Gibbons, M. D.

April 23, 1915 (Address) Crown Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Peter's R. Cemetery

April 25<sup>th</sup> 1915

20 UNDERTAKERS

ADDRESS

Young &amp; Lusby

Brandywine Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not zealously employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

MAY 5 1915

BUREAU, V. S.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Prince George's

5613

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

248

Village or City

Hyattsville

(No.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Lawrence H. Bursey

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

single

6 DATE OF BIRTH

July 29, 1913

(Month)

(Day)

(Year)

7 AGE

1 yrs. 8 mos. 24 ds.

If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

child

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

Md.

PARENTS

10 NAME OF FATHER

John L. Bursey

11 BIRTHPLACE OF FATHER  
(State or country)

Va

12 MAIDEN NAME OF MOTHER

Minnie Smith

13 BIRTHPLACE OF MOTHER  
(State or country)

Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Minnie Bursey

(Address)

Hyattsville Md.

15

Filed

April 27, 1915

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 25, 1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at 2. P. M.

The CAUSE OF DEATH\* was as follows:

accidental gunshot wound

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

Louis O. Wiseman, Jr., M.D.

191 (Address) acting coroner

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bladensburg Md.

April 27, 1915

20 UNDERTAKER

ADDRESS

F. J. Gasco's Sons

Bladensburg

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered, as *Housewife, Housework*, or *At Home*; and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Scallie," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* as such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 4 1915

BUREAU U. S. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County *St. Louis*Village or City *Aguasco* (No. *104*)

St.; Ward)

## 2 FULL NAME

*Edward Butler*STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *237*

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Single*

## 6 DATE OF BIRTH

*Jan 1 1915*  
(Month) (Day) (Year)

## 7 AGE

*4* yrs. *4* mos. *4* ds. OR *1* day, *1* hrs. *1* min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE (State or country)

10 NAME OF FATHER *John Bullin*11 BIRTHPLACE OF FATHER (State or country) *Ind*12 MAIDEN NAME OF MOTHER *Emily Brooks*13 BIRTHPLACE OF MOTHER (State or country) *Ind*

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Adam Glasgow*(Address) *Aguasco Ind*

## 15

Filed *May 18 1915* *Henry B. Carter*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

*Apr 30 1915*  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

*Apr 29 1915* to *Apr 30 1915*,  
that I last saw him alive on *Apr 29 1915*and that death occurred on the date stated above, at *8 2* m.

The CAUSE OF DEATH\* was as follows:

*Acute Gastritis*(Duration) *3* yrs. *3* mos. *3* ds.

Contributory (Secondary)

(Duration) *3* yrs. *3* mos. *3* ds.(Signed) *J. M. ...* M. D.*Apr 30 1915* (Address) *Aguasco Ind*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death *3* yrs. *3* mos. *3* ds. In the State *3* yrs. *3* mos. *3* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Aguasco Ind* *May 1 1915*

## 20 UNDERTAKER

## ADDRESS

*A. J. ...* *Aguasco Ind*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 da.; *Bronchopneumonia* (secondary), 10 da. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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|   |   |   |   |  |  |   |  |  |
|---|---|---|---|--|--|---|--|--|
| 1 PLACE OF DEATH<br>County <u>Prince George</u>   |   |   | 5615  |  |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH |  |  |
| Village or City <u>Camp Springs Md</u>  |   |   | (No. <u>38</u> )  |  |  | Registration Dist. No. <u>238</u>         |  |  |
| 2 FULL NAME <u>Harmon Carey</u>   |   |   | [If death occurred in a hospital or institution, give its NAME instead of street and number.] |  |  |   |  |  |
| PERSONAL AND STATISTICAL PARTICULARS  |   |   |   |  |  |   |  |  |
| 3 SEX<br><u>Male</u>  | 4 COLOR OR RACE<br><u>White</u>   | 5 SINGLE, MARRIED, WIDOWED OR DIVORCED<br><u>Single</u><br>(Write the word)           |   |  |  |   |  |  |
| 6 DATE OF BIRTH<br><u>unknown</u>   |   | 7 AGE<br><u>35</u> yrs. <u>0</u> mos. <u>0</u> ds. If LESS than 1 day, hrs. OR min. ? |   |  |  |   |  |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work<br><u>Domestic</u><br>(b) General nature of industry, business, or establishment in which employed (or employer)  |   | 9 BIRTHPLACE<br>(State or country)<br><u>Ireland</u>                                  |   |  |  |   |  |  |
| PARENTS   | 10 NAME OF FATHER<br><u>unknown</u>   |   | 11 BIRTHPLACE OF FATHER<br>(State or country)<br><u>unknown</u>                               |  |  |   |  |  |
|   | 12 MAIDEN NAME OF MOTHER<br><u>unknown</u>  |   | 13 BIRTHPLACE OF MOTHER<br>(State or country)<br><u>unknown</u>                               |  |  |   |  |  |
|   | 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Anna M. Schneider</u><br>(Address) <u>Camp Springs</u> |   |   |  |  |   |  |  |
|   | 15 Filed <u>Apr 24, 1915</u> <u>Mary W. Thomas</u><br>REGISTRAR   |   |   |  |  |   |  |  |
| MEDICAL CERTIFICATE OF DEATH  |   |   |   |  |  |   |  |  |
| 16 DATE OF DEATH<br><u>Apr 24, 1915</u><br>(Month) (Day) (Year)   |   |   |   |  |  |   |  |  |
| 17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____ alive on _____, 191____, and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH * was as follows:<br><u>Not doctor in attendance</u><br><u>supposed acute indigestion</u><br>(Duration) _____ yrs. _____ mos. _____ ds.<br>Contributory <u>Tuberculosis</u><br>Secondary <u>Sudden</u><br>(Signed) <u>John E. Sappington, M.D.</u><br><u>Apr 24, 1915</u> (Address) <u>Wheatville Md.</u><br>* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and, (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL. |   |   |   |  |  |   |  |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death _____ yrs. _____ mos. _____ ds. In the State, _____ yrs. _____ mos. _____ ds.<br>Where was disease contracted, _____<br>If not at place of death? _____<br>Former or usual residence _____   |   |   |   |  |  |   |  |  |
| 19 PLACE OF BURIAL OR REMOVAL<br><u>Wash. D.C.</u>  |   |   |   |  |  | DATE OF BURIAL<br><u>Apr 26, 1915</u>     |  |  |
| 20 UNDERTAKER<br><u>Hysong &amp; Barnette</u>   |   |   |   |  |  | ADDRESS<br><u>Wash. D.C.</u>              |  |  |

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds., *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness" etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or NONFATAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Roadster wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
MAY 5 1915  
BUREAU, V. S.

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## 1 PLACE OF DEATH

County P & C CoVillage or City Hyattsville (No. \_\_\_\_\_)

St.; \_\_\_\_\_ Ward \_\_\_\_\_

Registration Dist. No. 245

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Samuel Edward Chase

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widower  
(Write the word)

6 DATE OF BIRTH 18 64  
(Month) July (Day) 1 (Year) 1904

7 AGE 51 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. OR \_\_\_\_\_ min. ?  
IF LESS than 1 day, \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Caring chairs  
(b) General nature of industry, business, or establishment in which employed (or employer) home

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (State or country) Not known

12 MAIDEN NAME OF MOTHER Harriela Wells

13 BIRTHPLACE OF MOTHER (State or country) Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma Wright  
(Address) 1300 St Hyattsville

15 Filed April 17, 1915 Mrs. J. S. Severe REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 16, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1915, to April 14, 1915, that I last saw him alive on April 14, 1915

and that death occurred on the date stated above, at 2 1/2 m.

The CAUSE OF DEATH\* was as follows:

Bronchitis pneumonia

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Gravel  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) H. B. Wells, M. D.

April 17, 1915 (Address) Hyattsville

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bladensburg Md April 18, 1915

20 UNDERTAKER ADDRESS

H. Gasch's Sons Bladensburg Md

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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MAY 4 1915

BUREAU, V. S.

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1 PLACE OF DEATH  
County Prince George

Village or City Brown Creek (No. \_\_\_\_\_)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 241

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Emily Clark

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH June 30, 1890  
(Month) (Day) (Year)

7 AGE 74 yrs. 9 mos. 30 ds. OR 1 day, 8 hrs. 40 min. ?  
If LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Onondaga Co. N. Y.

PARENTS  
10 NAME OF FATHER Daniel Rabin  
11 BIRTHPLACE OF FATHER (State or country) New York  
12 MAIDEN NAME OF MOTHER Amanda Bass  
13 BIRTHPLACE OF MOTHER (State or country) New York

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mary H. Clark

(Address) Cornwall St. Bk

15 Filed Apr 4, 1916 J. M. McGeown  
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 2<sup>nd</sup>, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1914, to April 2, 1915,  
that I last saw h. er alive on April 1<sup>st</sup>, 1915

and that death occurred on the date stated above, at 6 A m.

The CAUSE OF DEATH\* was as follows:

Diabetes mellitus  
senile gangrene

(Duration) \_\_\_\_\_ yrs. 4 mos. 17 ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Charles E. Benson, M. D.  
April 2, 1915 (Address) Cornwall St. Bk

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Green Hill Mt. DATE OF BURIAL April 4, 1915

20 UNDERTAKER Thomas Murray ADDRESS Washington D. C.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

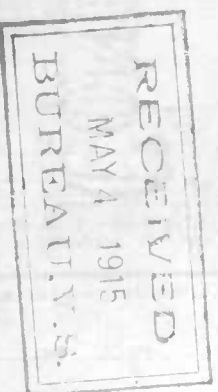
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Œmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accidental*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| 1 PLACE OF DEATH   |  | 5618 STATE OF MARYLAND  |  |
|--|--|---|--|
| County <u>Prince George</u>  |  | CERTIFICATE OF DEATH  |  |
| Village or City <u>Collington</u> (No. <u>5</u> )  |  | Registration Dist. No. <u>343</u>   |  |
| 2 FULL NAME <u>Nellie Irene Clarke</u>   |  | [If death occurred in a hospital or institution, give its NAME instead of street and number.] |  |
| PERSONAL AND STATISTICAL PARTICULARS   |  |   |  |
| 3 SEX<br><u>female</u>   | 4 COLOR OR RACE<br><u>white</u>                            | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br><u>married</u><br>(Write the word)                 |  |
| 6 DATE OF BIRTH<br><u>January 10</u> , 18 <u>92</u><br>(Month) (Day) (Year)  |  |   |  |
| 7 AGE<br><u>23</u> yrs. <u>4</u> mos. <u></u> ds. If LESS than 1 day, <u></u> hrs. OR <u></u> min. ?   |  |   |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>housewife</u><br>(b) General nature of industry, business, or establishment in which employed (or employer)   |  |   |  |
| 9 BIRTHPLACE (State or country) <u>Maryland</u>  |  |   |  |
| PARENTS  | 10 NAME OF FATHER <u>Joseph Cross</u>                      |   |  |
|  | 11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u> |   |  |
|  | 12 MAIDEN NAME OF MOTHER <u>Katherine Shaw</u>             |   |  |
|  | 13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u> |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Ernest G. Clarke</u><br>(Address) <u>Collington, Maryland</u>   |  |   |  |
| 15 Filed <u>April 25, 1915</u> <u>Nelson Ryon</u> REGISTRAR  |  |   |  |
| MEDICAL CERTIFICATE OF DEATH   |  |   |  |
| 16 DATE OF DEATH <u>April 22</u> , 191 <u>5</u><br>(Month) (Day) (Year)  |  |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>April 8</u> , 191 <u>5</u> , to <u>April 22</u> , 191 <u>5</u> , that I last saw her alive on <u>April 22</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>9 P.</u> m. The CAUSE OF DEATH* was as follows:<br><u>Rheumatic fever</u> |  |   |  |
| (Duration) <u>1</u> yrs. <u>12</u> mos. <u></u> ds.  |  |   |  |
| Contributory (Secondary) <u>Ecchymosis</u>   |  |   |  |
| (Duration) <u></u> yrs. <u></u> mos. <u></u> ds.   |  |   |  |
| (Signed) <u>J. M. Dargatz</u> , M. D.<br><u>April 23</u> , 191 <u>5</u> (Address) <u>Springfield Md.</u>   |  |   |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  |  |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death <u></u> yrs. <u></u> mos. <u></u> ds. In the State <u></u> yrs. <u></u> mos. <u></u> ds.<br>Where was disease contracted, If not at place of death?<br>Former or usual residence <u></u>                    |  |   |  |
| 19 PLACE OF BURIAL OR REMOVAL<br><u>White Marsh</u>  |  | DATE OF BURIAL<br><u>Apr 25</u> , 191 <u>5</u>  |  |
| 20 UNDERTAKER<br><u>M. F. Hadley &amp; Sons</u>  |  | ADDRESS   |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anaemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

MAY 5 1915

BUREAU, U. S.

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## 1 PLACE OF DEATH

County

Village or City

(No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 247

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Caucasian

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Nov. 20, 1874

7 AGE

34 41

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

House wife

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

North Carolina

10 NAME OF FATHER

Thomas H. Jones

11 BIRTHPLACE OF FATHER

(State or country)

North Carolina

12 MAIDEN NAME OF MOTHER

Elizabeth Carter

13 BIRTHPLACE OF MOTHER

(State or country)

North Carolina

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

April 7, 1915 John E. Weaver

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 6, 1915

17 I HEREBY CERTIFY That I attended deceased from

Jan. 6, 1915 to April 6, 1915, that I last saw her alive on April 5, 1915, and that death occurred on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH was as follows:

Carcinoma of Breast (right) and axilla

(Duration) yrs. mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed)

Miller W. Jones, M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE, CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Charlotte W. B. April 8, 1915

20 UNDERTAKER

ADDRESS

John T. Stewart 30-44-23

If more blanks are needed, address State Registrar, 10 W. Saratoga St., Balto., Requesting V. S. No. 1.

D.C.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

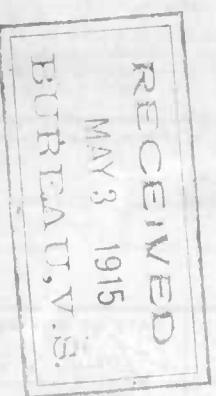
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**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection, with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDE, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Prince Georges  
Village or City Collington (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
2 FULL NAME Sarah A. Corill  
STATE OF MARYLAND  
CERTIFICATE OF DEATH  
Registration Dist. No. 236  
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Jan. 10, 1842  
(Month) (Day) (Year)

7 AGE 73 yrs. 2 mos. 29 ds. If LESS than 1 day, .... hrs. OR .... min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) England

10 NAME OF FATHER George Ford

11 BIRTHPLACE OF FATHER (State or country) England

12 MAIDEN NAME OF MOTHER Sarah Walker

13 BIRTHPLACE OF MOTHER (State or country) England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Millie Corill

(Address) Collington Md.

15 Filled \_\_\_\_\_, 1915

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 8th, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from investigated, to \_\_\_\_\_, 1915

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 1915

and that death occurred on the date stated above, at 12.05 P. m.

The CAUSE OF DEATH\* was as follows:

due to Natural causes. (Paralysis)  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Found paralyzed by husband  
(Secondary) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Samuel M. Leonberger, M.D.  
Apr. 9th, 1915 (Address) Mitchellville Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. to the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Ship to Pa DATE OF BURIAL \_\_\_\_\_, 1915

20 UNDERTAKER Frank Wood ADDRESS Mitchellville



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

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RECEIVED

MAY 6 1915

BUREAU, U. S.

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| 1 PLACE OF DEATH   |   |   | 5620                   |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH |                                  |  |
|--|---|---|------------------------|--|---|----------------------------------|--|
| County <u>P. Geo.</u>  |   |   | (S)                    |  | Registration Dist. No. <u>234</u>         |                                  |  |
| Village or City <u>Ft. Washington</u>  |   |   | St. <u>Crutchfield</u> |  | Ward _____                                |                                  |  |
| 2 FULL NAME _____  |   |   |                        |  |   |                                  |  |
| PERSONAL AND STATISTICAL PARTICULARS   |   |   |                        |  |   |                                  |  |
| 3 SEX<br><u>Fe.</u>  | 4 COLOR OR RACE<br><u>B.</u>                          | 5 SINGLE, MARRIED, WIDOWED OR DIVORCED<br><u>S.</u><br>(Write the word) |                        |  |   |                                  |  |
| 6 DATE OF BIRTH <u>Apr. 14, 1915</u><br>(Month) (Day) (Year)   |   |   |                        |  |   |                                  |  |
| 7 AGE _____ If LESS than 1 day, _____ hrs. _____ yrs. _____ mos. _____ ds. OR _____ mo. _____  |   |   |                        |  |   |                                  |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work _____<br>(b) General nature of industry, business, or establishment in which employed (or employer) _____  |   |   |                        |  |   |                                  |  |
| 9 BIRTHPLACE (State or country) <u>Md.</u>   |   |   |                        |  |   |                                  |  |
| PARENTS  | 10 NAME OF FATHER <u>Walter Crutchfield</u>           |   |                        |  |   |                                  |  |
|  | 11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u> |   |                        |  |   |                                  |  |
|  | 12 MARRIAGE NAME OF MOTHER <u>Annie Bolden</u>        |   |                        |  |   |                                  |  |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>   |   |   |                        |  |   |                                  |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Walter Crutchfield</u><br>(Address) <u>Ft. Washington, Md.</u>  |   |   |                        |  |   |                                  |  |
| 15 Filed <u>4/14, 1915</u> <u>E. W. Hurtt</u><br>REGISTRAR   |   |   |                        |  |   |                                  |  |
| MEDICAL CERTIFICATE OF DEATH   |   |   |                        |  |   |                                  |  |
| 16 DATE OF DEATH <u>Apr. 14, 1915</u><br>(Month) (Day) (Year)  |   |   |                        |  |   |                                  |  |
| 17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,<br>that I last saw him _____ alive on _____, 191____,<br>and that death occurred on the date stated above, at _____ m.<br>The CAUSE OF DEATH * was as follows:<br><u>Still-Born</u><br>(Duration) _____ yrs. _____ mos. _____ ds.      |   |   |                        |  |   |                                  |  |
| Contributory Secondary<br>(Duration) _____ yrs. _____ mos. _____ ds.<br>(Signed) <u>Edgar W. Hurtt</u> M. D.<br><u>april 14, 1915</u> (Address) <u>Piscataway, Md.</u><br>*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL. |   |   |                        |  |   |                                  |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place _____ In the _____<br>of death _____ yrs. _____ mos. _____ ds. State, _____ yrs. _____ mos. _____ ds.<br>Where was disease contracted, _____<br>If not at place of death? _____<br>Former or usual residence _____         |   |   |                        |  |   |                                  |  |
| 19 PLACE OF BURIAL OR REMOVAL <u>Chapel Hill Cem.</u>  |   |   |                        |  |   | DATE OF BURIAL <u>4/14, 1915</u> |  |
| 20 UNDERTAKER <u>Wm. Hawkins</u>   |   |   |                        |  |   | ADDRESS <u>Ft. Washington</u>    |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

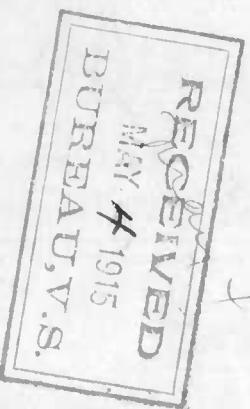
[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Auto mobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



*sent out for signature,*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| 1 PLACE OF DEATH  |                                 |   | 5621 STATE OF MARYLAND  |  |
|---|---------------------------------|---|---|--|
| County <u>Prince Georges Co</u>   |                                 |   | CERTIFICATE OF DEATH  |  |
| Village or City <u>Oxon Hill</u> (No. <u>15</u> )   |                                 |   | Registration Dist. No. <u>241</u>   |  |
| 2 FULL NAME <u>Murray Dean Jr</u>   |                                 |   | [It death occurred in a hospital or institution, give its NAME instead of street and number.] |  |
| <b>PERSONAL AND STATISTICAL PARTICULARS</b>   |                                 |   |   |  |
| 3 SEX<br><u>male</u>  | 4 COLOR OR RACE<br><u>white</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>single</u> |   |  |
| 6 DATE OF BIRTH <u>April 22<sup>nd</sup></u> , 1915<br>(Month) (Day) (Year)   |                                 |   |   |  |
| 7 AGE _____ yrs. _____ mos. <u>one hour</u> If LESS than 1 day, ____ hrs. ____ min. ?   |                                 |   |   |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>none</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) <u>none</u>   |                                 |   |   |  |
| 9 BIRTHPLACE (State or country) <u>Prince Georges Co Maryland</u>   |                                 |   |   |  |
| 10 NAME OF FATHER <u>Jas. M. Dean</u>   |                                 |   |   |  |
| 11 BIRTHPLACE OF FATHER (State or country) <u>D.C.</u>  |                                 |   |   |  |
| 12 MAIDEN NAME OF MOTHER <u>Bessie J. Birney</u>  |                                 |   |   |  |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Dist. of Cal</u>  |                                 |   |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>J. C. Watson</u><br>(Address) <u>Anacostia D.C.</u>  |                                 |   |   |  |
| 15 Filed <u>Apr 23</u> , 1915 <u>J. H. McKeown</u><br>Local REGISTRAR   |                                 |   |   |  |
| <b>MEDICAL CERTIFICATE OF DEATH</b>   |                                 |   |   |  |
| 16 DATE OF DEATH <u>April 22<sup>nd</sup></u> , 1915<br>(Month) (Day) (Year)  |                                 |   |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>birth April 1915</u> to <u>April 22</u> , 1915, that I last saw him alive on <u>11:20 am April 22</u> , 1915, and that death occurred on the date stated above, at <u>12:20 P</u> m.  |                                 |   |   |  |
| The CAUSE OF DEATH* was as follows:<br><u>Congenital debility</u><br><u>Premature birth (5 mos)</u><br>(Duration) _____ yrs. _____ mos. _____ ds.   |                                 |   |   |  |
| Contributory<br>Secondary<br>(Duration) _____ yrs. _____ mos. _____ ds.   |                                 |   |   |  |
| (Signed) <u>J. C. Watson</u> M. D.<br><u>Apr. 23</u> , 1915 (Address) <u>Anacostia D.C.</u>   |                                 |   |   |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.   |                                 |   |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.<br>Where was disease contracted, If not at place of death?<br>Former or usual residence _____ |                                 |   |   |  |
| 19 PLACE OF BURIAL OR REMOVAL<br><u>St. Barnabas Cem -</u>  |                                 |   | DATE OF BURIAL<br><u>Apr. 23, 1915</u>  |  |
| 20 UNDERTAKER<br><u>Murray Dean Oxon Hill</u>   |                                 |   | ADDRESS   |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 4 1915

BUREAU, V. S.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

5622

**STATE OF MARYLAND  
CERTIFICATE OF DEATH**

County Prince Georges Registration Dist. No. 283

Village or City Crown (No. 07) St.        Ward       

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

**2<sup>nd</sup> FULL NAME** James T. DeVaughn

| PERSONAL AND STATISTICAL PARTICULARS   |  |   | MEDICAL CERTIFICATE OF DEATH  |  |
|--|--|---|---|--|
| 3 SEX<br><u>Male</u>   | 4 COLOR OR RACE<br><u>White</u>                      | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>married</u>  | 16 DATE OF DEATH <u>April 10</u> , 191 <u>5</u><br>(Month) (Day) (Year)   |  |
| 6 DATE OF BIRTH <u>July 11</u> , 18 <u>65</u><br>(Month) (Day) (Year)  |  |   | 17 I HEREBY CERTIFY, That I attended deceased from <u>April 4</u> , 191 <u>5</u> , to <u>April 10</u> , 191 <u>5</u> ,<br>that I last saw him alive on <u>April 10</u> , 191 <u>5</u>                                   |  |
| 7 AGE <u>50</u> yrs. <u>1</u> mos. <u>28</u> ds. OR <u>      </u> min. ?<br>If LESS than 1 day, hrs.   |  |   | and that death occurred on the date stated above, at <u>1:30 P.</u> m.<br>The CAUSE OF DEATH* was as follows:<br><u>Acute Bacterial Pneumonia</u><br>(Duration) <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds. |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>Limberman</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) <u>      </u> |  |   | Contributory <u>      </u><br>Secondary <u>      </u><br>(Duration) <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds.   |  |
| 9 BIRTHPLACE (State or country) <u>md</u>  |  |   | (Signed) <u>W. H. Gibbons</u> , M. D.<br><u>April 11</u> , 191 <u>5</u> (Address) <u>Crown md</u>   |  |
| PARENTS  | 10 NAME OF FATHER <u>John T. DeVaughn</u>            |   | *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.   |  |
|  | 11 BIRTHPLACE OF FATHER (State or country) <u>md</u> |   |   |  |
|  | 12 MAIDEN NAME OF MOTHER <u>Sarah R. Hyde</u>        |   |   |  |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>md</u>   |  | 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds. In the State <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds.<br>Where was disease contracted, if not at place of death? <u>      </u><br>Former or usual residence <u>      </u> |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>A. Preston DeVaughn</u><br>(Address) <u>North Keys md</u>   |  |   |   |  |
| 15 Filed <u>April 12</u> , 191 <u>5</u> <u>Ernest V. Garner</u><br>REGISTRAR   |  |   | 19 PLACE OF BURIAL OR REMOVAL <u>St Thomas Church Road</u> DATE OF BURIAL <u>April 12</u> , 191 <u>5</u><br>20 UNDERTAKER <u>Shamp Bros</u> ADDRESS <u>North Kensington Md</u>  |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

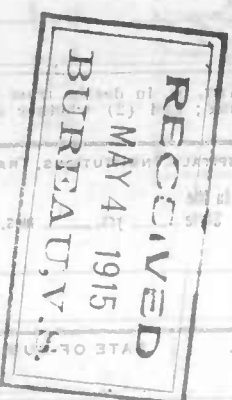
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., or..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County

Village or City

(No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *230*

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*Black*5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)*Unknown*

## 6 DATE OF BIRTH

*Unknown*  
(Month) (Day) (Year)

## 7 AGE

*about 80* yrs. mos. ds. OR min. ?  
If LESS than  
1 day, hrs.

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

*Laborer*

(b) General nature of industry business, or establishment in which employed (or employer)

*Janitor work*9 BIRTHPLACE  
(State or country)*Md*

## PARENTS

## 10 NAME OF FATHER

*Unknown*11 BIRTHPLACE OF FATHER  
(State or country)*Unknown*

## 12 MAIDEN NAME OF MOTHER

*Unknown*13 BIRTHPLACE OF MOTHER  
(State or country)*Unknown*

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Henry E. Nicholson*

(Address)

*Frostville Md*

## 15

Filed

*April 25, 1915*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

*4* / *1* / *1915*  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *March 30, 1915*, to *April 1, 1915*, that I last saw him alive on *March 31, 1915*, and that death occurred on the date stated above, at *4 p.m.*

The CAUSE OF DEATH was as follows:

*Chronic Nephritis*Contributory *Legionnaires Disease*  
Secondary

(Signed)

*John E. Drisham*, M. D.  
*April 1st 1915* (Address) *Frostville Md*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*County Calverton Prince Georges**April 2, 1915*

## 20 UNDERTAKER

## ADDRESS

*Henry Nicholson**Frostville Md*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who the engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asheina," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Roadster wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Village or City

(No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 247

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

## PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH was as follows:

Contributory

Secondary

(Signed)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Mill engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Woolery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." Foreman, "Manager," "Dealer," etc., without more precise specification as *Dog laborer*, *Farm laborer*, *Indigermine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*gus, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tranmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Prenatal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 3 1915

BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| 1 PLACE OF DEATH  |  |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH |  |
|---|--|--|---|--|
| County <u>Prince Geo.</u>   |  |  | Registration Dist. No. <u>239</u>         |  |
| Village or City <u>Laurel</u> (No. <u>105</u> )   |  |  | St.; <u>      </u> Ward <u>      </u>     |  |
| 2 FULL NAME <u>Lottie A. Fillmore</u>   |  |  |   |  |
| PERSONAL AND STATISTICAL PARTICULARS  |  |  |   |  |
| 3 SEX<br><u>Female</u>  | 4 COLOR OR RACE<br><u>White</u>                              | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>Widowed</u> |   |  |
| 6 DATE OF BIRTH <u>Unknown</u> , 18 <u>50</u><br>(Month) (Day) (Year)   |  |  |   |  |
| 7 AGE <u>64</u> yrs. <u>      </u> mos. <u>      </u> ds. OR <u>      </u> min. ?<br>If LESS than 1 day, <u>      </u> hrs.   |  |  |   |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>None</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) <u>      </u>   |  |  |   |  |
| 9 BIRTHPLACE (State or country) <u>Washington D.C.</u>  |  |  |   |  |
| PARENTS   | 10 NAME OF FATHER <u>Thos. Noxfleet</u>                      |  |   |  |
|   | 11 BIRTHPLACE OF FATHER (State or country) <u>Do.</u>        |  |   |  |
|   | 12 MAIDEN NAME OF MOTHER <u>Susanna Dawson</u>               |  |   |  |
|   | 13 BIRTHPLACE OF MOTHER (State or country) <u>Wash. D.C.</u> |  |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>H. S. Brown</u><br>(Address) <u>Laurel Sanitarium</u>  |  |  |   |  |
| 15 Filed <u>Apr. 28th</u> , 191 <u>5</u> <u>Wm. A. Fairall</u><br>REGISTRAR   |  |  |   |  |
| MEDICAL CERTIFICATE OF DEATH  |  |  |   |  |
| 16 DATE OF DEATH <u>April 27</u> , 191 <u>5</u><br>(Month) (Day) (Year)   |  |  |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Dec 8</u> , 191 <u>1</u> , to <u>April 27</u> , 191 <u>5</u> ,<br>that I last saw him alive on <u>Apr 27</u> , 191 <u>5</u> ,<br>and that death occurred on the date stated above, at <u>4:30 a.m.</u> ,<br>The CAUSE OF DEATH* was as follows:<br><u>Diarrhoea &amp; enteritis</u> |  |  |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death <u>3</u> yrs. <u>19</u> mos. <u>19</u> ds. In the State <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds.<br>Where was disease contracted, If not at place of death?<br>Former or usual residence <u>Washington D.C.</u> |  |  |   |  |
| 19 PLACE OF BURIAL OR REMOVAL <u>Laurel Sanitarium</u> DATE OF BURIAL <u>April 29</u> , 191 <u>5</u>  |  |  |   |  |
| 20 UNDERTAKER <u>Geo. E. French</u> ADDRESS <u>Laurel Md</u>  |  |  |   |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia*; ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
MAY 5 1915  
BUREAU, N. H.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County

Prince George's

Village or City

New Dealbrook

(No.

5625

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

243

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Charles E. G. G. G.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
ORDIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

not known not known

(Month) (Day) (Year)

7 AGE

60

yrs.

mos.

ds.

If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work

Farmer

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF  
FATHER

not known

11 BIRTHPLACE  
OF FATHER  
(State or country)

not known

12 MAIDEN NAME  
OF MOTHER

not known

13 BIRTHPLACE  
OF MOTHER  
(State or country)

not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Albert G. Simpson

(Address)

Mitchellville Md.

15

Filed

April 24, 1915 Nelson A. Ryan md

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 22, 1914

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

April 21, 1914 to April 22, 1914

that I last saw him alive on April 22, 1914

and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH\* was as follows:

Bronchial Pneumonia  
+ Pharyngitis

not exactly known

(Duration) yrs. mos. ds.

Contributory  
Secondary

Cardiac Asthma

(Duration) yrs. mos. ds.

(Signed)

J. M. D. Wall

M. D.

April 23, 1914 (Address) Springfield Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Barnabas Md.

April 24, 1914

20 UNDERTAKER

ADDRESS

Edward E. Gosh

Bladensburg Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

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[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative helpfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probable such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAY 5 1915  
BUREAU, V. S.



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1 PLACE OF DEATH  
County Pr. George 5620  
Village or City Townshend (No. 10) St.; Ward)  
2 FULL NAME Pliny J. Garner Registration Dist. No. 240  
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widower  
(Write the word)

6 DATE OF BIRTH March not known, 1865  
(Month) (Day) (Year)

7 AGE 58 yrs. about If LESS than 1 day, hrs. OR min. ?  
mos. ds.

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Laborer  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) MD

PARENTS  
10 NAME OF FATHER Jos. Milo Garner  
11 BIRTHPLACE OF FATHER (State or country) MD  
12 MAIDEN NAME OF MOTHER Rose A. Cooke  
13 BIRTHPLACE OF MOTHER (State or country) MD

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Walter Baden  
(Address) Bedfordville

15 Filed Apr. 15<sup>th</sup>, 1915 J. K. Smith  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr. 15, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr 8, 1915, to Apr. 14, 1915,  
that I last saw him alive on Apr 14, 1915.

and that death occurred on the date stated above, at 4 a. m.  
The CAUSE OF DEATH\* was as follows:

Scrubber  
3 (Duration) yrs. mos. 21 ds.

Contributory  
Secondary (Duration) yrs. mos. ds.

(Signed) John A. Cox, M. D.  
Apr 15, 1915 (Address) Brandywine

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death yrs. mos. ds. In the State yrs. mos. ds.  
Where was disease contracted,  
If not at place of death?  
Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
St. Peter's C. Cemetery Apr. 16<sup>th</sup>, 1915  
20 UNDERTAKER ADDRESS  
Hunt & Ryan Waldorf Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

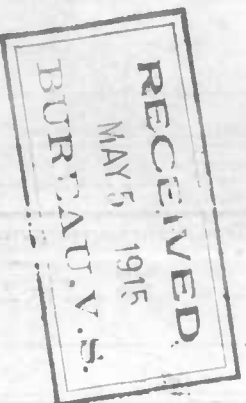
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*, *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) infection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Ivanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCELERATED, SUICIDAL, or NONSUICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Repeater wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on nomenclature of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITING PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

*Prince Georges*

Village or City

*Farmington Heights*

(No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

*247*

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

*Francis Earl Gennis*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*colored*5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)*single*

6 DATE OF BIRTH

*April - 13, 1915*  
(Month) (Day) (Year)

7 AGE

yrs. mos. ds.

If LESS than  
1 day, 3 hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

*infant*

(b) General nature of industry business, or establishment in which employed (or employer)

*same*

9 BIRTHPLACE

(State or country)

*Ind.*

## PARENTS

10 NAME OF FATHER

*James Gennis*

11 BIRTHPLACE OF FATHER

(State or country)

*Ind.*

12 MAIDEN NAME OF MOTHER

*Hattie Arthur*

13 BIRTHPLACE OF MOTHER

(State or country)

*Ind.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Hattie Gennis*

(Address)

*Farmington Heights Ind.*

15

Filed

*April 15, 1915 John E. Ward local*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*April 13, 1915*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

*April 13, 1915, to*, 1915,that I last saw him alive on *April 13, 1915,*and that death occurred on the date stated above, at *1 P. m.*

The CAUSE OF DEATH \* was as follows:

Contributory

Secondary

(Duration) yrs. mos. ds.

(Signed)

*Dr. Brady*  
*April 14, 1915* (Address) *Rockville, Md.*

M. O.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds.

In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Washington D. C.* *April 15, 1915*

20 UNDERTAKER

ADDRESS

*R. M. Perry.* *H. St. N. E.*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

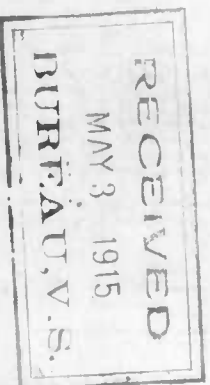
[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mucositis*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as *accidental*, *suicidal*, or *homicidal*, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1 PLACE OF DEATH<br>County <u>Penn. Dungs</u>   |  | 5628<br>(517)  |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH  |  |
| Village or City <u>Laurel</u> (No. _____)   |  | Registration Dist. No. <u>239</u>  |  | St.; _____ Ward)                           |  |
| 2 FULL NAME <u>Eliza Day (Mrs)</u>  |  |  |  |  |  |
| PERSONAL AND STATISTICAL PARTICULARS  |  |  |  |  |  |
| 3 SEX<br><u>Female</u>  | 4 COLOR OR RACE<br><u>White</u>                            | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)<br><u>Widow</u> |  |  |  |
| 6 DATE OF BIRTH <u>Unknown</u> , 18 <u>53</u><br>(Month) (Day) (Year)   |  |  |  |  |  |
| 7 AGE <u>62</u> yrs. <u>✓</u> mos. <u>✓</u> ds. <u>✓</u><br>It LESS than 1 day, _____ hrs. OR _____ min. ?  |  |  |  |  |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>None</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) <u>✓</u>  |  |  |  |  |  |
| 9 BIRTHPLACE (State or country) <u>Virginia</u>   |  |  |  |  |  |
| PARENTS   | 10 NAME OF FATHER <u>James Powell</u>                      |  |  |  |  |
|   | 11 BIRTHPLACE OF FATHER (State or country) <u>Virginia</u> |  |  |  |  |
|   | 12 MAIDEN NAME OF MOTHER <u>Calvinia Jacobs</u>            |  |  |  |  |
|   | 13 BIRTHPLACE OF MOTHER (State or country) <u>Virginia</u> |  |  |  |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>L. W. Ellis</u><br>(Address) <u>Laurel Md</u>  |  |  |  |  |  |
| 15 Filed <u>May 1st</u> 191 <u>5</u> <u>Wm. A. Fairall</u><br>REGISTRAR   |  |  |  |  |  |
| MEDICAL CERTIFICATE OF DEATH  |  |  |  |  |  |
| 16 DATE OF DEATH <u>April</u> <u>29</u> , 191 <u>5</u><br>(Month) (Day) (Year)  |  |  |  |  |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>April 15</u> , 191 <u>5</u> , to <u>April 29</u> , 191 <u>5</u> ,<br>that I last saw her alive on <u>April 29</u> , 191 <u>5</u> ,<br>and that death occurred on the date stated above, at <u>9:20 P.</u> m.<br>The CAUSE OF DEATH* was as follows:<br><u>Lobar Pneumonia</u> |  |  |  |  |  |
| Contributory (Secondary) <u>Chronic Valvular Heart Disease</u><br>(Duration) _____ yrs. <u>15</u> mos. <u>15</u> ds.<br>(Signed) <u>Dr. W. Jones</u> , M. D.<br><u>April 30</u> , 191 <u>5</u> (Address) <u>Laurel</u>  |  |  |  |  |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.   |  |  |  |  |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.<br>Where was disease contracted, If not at place of death?<br>Former or usual residence _____   |  |  |  |  |  |
| 19 PLACE OF BURIAL OR REMOVAL <u>Day Hill Cemetery</u>  |  |  |  | DATE OF BURIAL <u>May 1</u> , 191 <u>5</u> |  |
| 20 UNDERTAKER <u>Dr. E. Smith</u>   |  |  |  | ADDRESS <u>Laurel</u>                      |  |



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

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*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anaemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
MAY 5 1915  
BUREAU, V. S.

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## 1 PLACE OF DEATH

County Prince George'sVillage or City Mt Rainier No. 56292 FULL NAME Mrs. A. B. GreenSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 248

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Sept - 15, 1847  
(Month) (Day) (Year)

7 AGE 67 yrs. 7 mos. 8 ds. If LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Friedenau County Md

10 NAME OF FATHER Joseph Christ

11 BIRTHPLACE OF FATHER (State or country) Montgomery Co Md

12 MAIDEN NAME OF MOTHER Barry Schiffer

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. Green(Address) 308-10 1/2 St NW Wash DC

15

Filed Apr 23, 1915 J. C. Olenkoff

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 23, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug, 1913, to April 23, 1915, that I last saw her alive on April 12, 1915.

and that death occurred on the date stated above, at 8:15 a.m.

The CAUSE OF DEATH\* was as follows:

Hemiplegia(Duration) 3 yrs. \_\_\_\_ mos. \_\_\_\_ ds.Contributory (Secondary) Acute Indigestion(Duration) a few minutes yrs. \_\_\_\_ mos. \_\_\_\_ ds.(Signed) JohnsonApril 23, 1915. (Address) Mt Rainier, M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

Friedenau City Md Apr 26, 1915

20 UNDERTAKER

J. T. Ticker Sons Washington DC

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

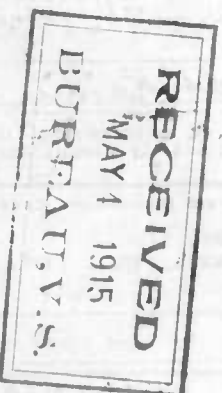
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*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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|  |   |  |  |
|--|---|--|--|
| 1 PLACE OF DEATH<br>County <u>Pr. Geo's</u>  |   | STATE OF MARYLAND<br>CERTIFICATE OF DEATH                                    |  |
| Village or City <u>Clinton</u> (No. <u>71</u> )  |   | Registration Dist. No. <u>238</u>  |  |
| 2 FULL NAME <u>John Henry Greene</u>   |   |  |  |
| PERSONAL AND STATISTICAL PARTICULARS   |   |  |  |
| 3 SEX<br><u>male</u>   | 4 COLOR OR RACE<br><u>colored</u>                     | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br><u>single</u><br>(Write the word) |  |
| 6 DATE OF BIRTH <u>Apr. 21, 1915</u><br>(Month) (Day) (Year)   |   |  |  |
| 7 AGE<br>— yrs. — mos. <u>8</u> ds.  |   | IT LESS THAN<br>1 day.....hrs.<br>OR.....min. ?                              |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>none</u><br>(b) General nature of industry, business, or establishment in which employed (or employer)  |   |  |  |
| 9 BIRTHPLACE (State or country) <u>md</u>  |   |  |  |
| PARENTS  | 10 NAME OF FATHER <u>Wm. E. Green</u>                 |  |  |
|  | 11 BIRTHPLACE OF FATHER (State or country) <u>md.</u> |  |  |
|  | 12 MAIDEN NAME OF MOTHER <u>Eliza Burroughs</u>       |  |  |
|  | 13 BIRTHPLACE OF MOTHER (State or country) <u>md</u>  |  |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Wm. E. Green</u><br>(Address) <u>Clinton, Md</u>  |   |  |  |
| 15 FILED <u>Apr 29, 1915, Mary W. Thomas</u><br>REGISTRAR  |   |  |  |
| MEDICAL CERTIFICATE OF DEATH   |   |  |  |
| 16 DATE OF DEATH <u>Apr 28, 1915</u><br>(Month) (Day) (Year)   |   |  |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>at birth</u><br>191....., to....., 191.....  |   |  |  |
| that I last saw him..... alive on....., 191.....   |   |  |  |
| and that death occurred on the date stated above, at..... m.   |   |  |  |
| The CAUSE OF DEATH* was as follows:<br><u>convulsions</u>  |   |  |  |
| (Duration)..... yrs. .... mos. .... ds.  |   |  |  |
| Contributory Secondary   |   |  |  |
| (Duration)..... yrs. .... mos. .... ds.  |   |  |  |
| (Signed) <u>John E. Sanbury</u> , M. D.<br><u>Apr 29, 1915</u> (Address) <u>Frostville, Md.</u>  |   |  |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.  |   |  |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.<br>Where was disease contracted, if not at place of death?<br>Former or usual residence..... |   |  |  |
| 19 PLACE OF BURIAL OR REMOVAL<br><u>Union Bethel C. F. B. Md</u>   |   | DATE OF BURIAL<br><u>Apr 29, 1915</u>  |  |
| 20 UNDERTAKER  |   | ADDRESS  |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 5 1915

PUBLIC HEALTH U. S.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Prince Georges

5630

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 248Village or City St. Pains

(No. ....)

St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Bornelius Horigan

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Widowed

6 DATE OF BIRTH

June171845

(Month)

(Day)

(Year)

7 AGE

70 yrs. 8 mos. 11 ds.If LESS than  
1 day, .... hrs.  
OR .... min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Ireland

PARENTS

10 NAME OF FATHER

Michael Horigan

11 BIRTHPLACE OF FATHER

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Margaret Scriven

13 BIRTHPLACE OF MOTHER

(State or country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Jennie Heston

(Address)

85 Maryland Ave. N. W. Wash. D. C.

15

Filed

April 5, 1915J. C. O'Leander, Jr.

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April41915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan 141914

to

April 41915that I last saw him alive on April 4, 1915and that death occurred on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Endocarditis(Duration) 1 yrs. 3 mos. .... ds.Contributory  
SecondaryChronic Nephritis(Duration) 1 yrs. .... mos. .... ds.

(Signed)

Harry Haller

M. D.

April 51915

(Address)

St. Pains

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

..... yrs. .... mos. .... ds.

In the

State

..... yrs. .... mos. .... ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Glennwood - Washington D. C.April 61915

20 UNDERTAKER

ADDRESS

Charles J. Gumbert301 E. Capitol St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmic," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

MAY 4 1915

BUREAU U. S. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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5631

STATE OF MARYLAND  
CERTIFICATE OF DEATH

County Prince George Registration Dist. No. 241

Village or City Croft Hill (No. \_\_\_\_\_) St.; \_\_\_\_\_ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

<sup>2</sup>FULL NAME Caroline Jennifer

| PERSONAL AND STATISTICAL PARTICULARS   |   |   | MEDICAL CERTIFICATE OF DEATH   |  |
|--|---|---|--|--|
| <sup>3</sup> SEX<br><u>Female</u>  | <sup>4</sup> COLOR OR RACE<br><u>Colored</u>                                    | <sup>5</sup> SINGLE, MARRIED, WIDDED, OR DIVORCED<br>(Write the word)<br><u>married</u> | <sup>16</sup> DATE OF DEATH <u>April 8<sup>th</sup></u> , 191 <u>5</u><br>(Month) (Day) (Year)   |  |
| <sup>6</sup> DATE OF BIRTH<br><u>Aug. 12<sup>th</sup></u> , 18 <u>41</u><br>(Month) (Day) (Year)   |   |   | <sup>17</sup> I HEREBY CERTIFY; That I attended deceased from <u>April 4<sup>th</sup></u> , 191 <u>5</u> , to <u>April 8<sup>th</sup></u> , 191 <u>5</u> .<br>that I last saw h <sup>e</sup> alive on <u>April 8<sup>th</sup></u> , 191 <u>5</u> .   |  |
| <sup>7</sup> AGE<br><u>73</u> yrs. <u>7</u> mos. <u>23</u> ds. <u>OR</u> 1 day, _____ hrs. _____ min. ?  |   |   | and that death occurred on the date stated above, at <u>5 P</u> m.<br>The CAUSE OF DEATH* was as follows:<br><u>Lobar Pneumonia</u>  |  |
| <sup>8</sup> OCCUPATION<br>(a) Trade, profession, or particular kind of work<br><u>Housework</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) |   |   | Contributory (Duration) _____ yrs. _____ mos. <u>4</u> ds.<br>Secondary <u>Acute Myocarditis</u>   |  |
| <sup>9</sup> BIRTHPLACE<br>(State or country) <u>Chesapeake, Md.</u>   |   |   | (Signed) <u>Charles E. Benson</u> , M.D.<br><u>April 8<sup>th</sup></u> , 191 <u>5</u> (Address) <u>Croft Hill, Md.</u>  |  |
| PARENTS  | <sup>10</sup> NAME OF FATHER<br><u>Wm. H. Benson</u>                            |   | *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2)* whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.   |  |
|  | <sup>11</sup> BIRTHPLACE OF FATHER<br>(State or country) <u>Chesapeake</u>      |   | <sup>18</sup> LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death _____ yrs. _____ mos. _____ ds. to the State _____ yrs. _____ mos. _____ ds.<br>Where was disease contracted, If not at place of death?<br>Former or usual residence _____ |  |
|  | <sup>12</sup> MAIDEN NAME OF MOTHER<br><u>Leah Collins</u>                      |   | <sup>19</sup> PLACE OF BURIAL OR REMOVAL<br><u>Oxon Hill</u>   |  |
|  | <sup>13</sup> BIRTHPLACE OF MOTHER<br>(State or country) <u>Chesapeake, Md.</u> |   | DATE OF BURIAL<br><u>Apr 11</u> , 191 <u>5</u>   |  |
| <sup>14</sup> THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>James Jennifer</u><br>(Address) <u>25 W. Benson St.</u>  |   |   | <sup>20</sup> UNDERTAKER<br><u>Adams &amp; Amos</u>  |  |
| <sup>15</sup> Filed <u>April 14<sup>th</sup></u> , 191 <u>5</u> <u>J. H. McKeown</u><br>Local REGISTRAR  |   |   | ADDRESS<br><u>Anacostia</u>  |  |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

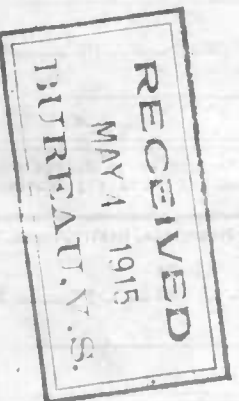
[Approved by U. S. Census and American Public Health Association.]

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## 1 PLACE OF DEATH

County

Prince Georges

5632

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 230

Village or City near Beltsville (No. ....)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

James Johnson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Caucas

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCEDSingle  
(Write the word)

6 DATE OF BIRTH

May 18, 1914  
(Month) (Day) (Year)

7 AGE

0 yrs 10 mos 17 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

Lakeland, Md.

## PARENTS

10 NAME OF FATHER

Joseph Johnson

11 BIRTHPLACE OF FATHER  
(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Maria Lomas

13 BIRTHPLACE OF MOTHER  
(State or country)

Muirkirk, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henrietta Jones

(Address)

Beltsville, Md.

15

Filed Apr 5th, 1915 John D Smith

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 4, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

March 26, 1915, to March 26, 1915

that I last saw him alive on March 26, 1915

and that death occurred on the date stated above, at 8<sup>00</sup> G. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(Duration) yrs. mos. 2 ds.

Contributory  
Secondary

Cholera

(Duration) yrs. mos. 10 ds.

(Signed)

W. Allen Gifford

M. D.

Apr 5, 1915 (Address) Beltsville, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Muirkirk, Md

April 6th, 1915

20 UNDERTAKER

ADDRESS

Fisher &amp; Chair

Laurel Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

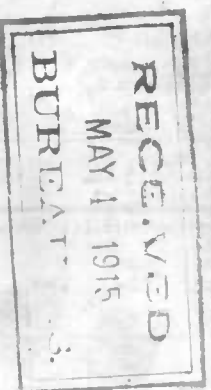
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic catarrhal heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Scule," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Prima Geo Co  
Village or City Laurel (No. 79) St.;        Ward         
2 FULL NAME Owen Leatherwood  
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS  
3 SEX Male 4 COLOR OR RACE White 5 SINGLE, Single  
~~MARRIED,~~  
~~WIDOWED,~~  
~~DIVORCED~~  
(Write the word)

6 DATE OF BIRTH Oct 14 1899  
(Month) (Day) (Year)

7 AGE 15 yrs. 5 mos. 25 ds. It LESS than  
1 day,        hrs. OR        min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work. None  
(b) General nature of industry, business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) Samuel. Md

PARENTS  
10 NAME OF FATHER Jas. A. Leatherwood  
11 BIRTHPLACE OF FATHER (State or country) Carroll Co Md.  
12 MAIDEN NAME OF MOTHER L. N. Ayton  
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Jas. A. Leatherwood  
(Address) Laurel, Md.

15 Filed Apr. 10 1915 Wm. A. Fairall  
REGISTRAR

16 DATE OF DEATH Apr. 9, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1, 1915, to Apr. 9, 1915,  
that I last saw him alive on Apr. 9, 1915,

and that death occurred on the date stated above, at 7 a. m.  
The CAUSE OF DEATH\* was as follows:

Cardiac Stenosis  
(Duration)        yrs.        mos. 4 ds.

Contributory Pneumonia  
Secondary  
(Duration)        yrs.        mos. 9 ds.  
(Signed) J. R. Smith, M. D.  
Apr 9, 1915 (Address) Laurel

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death        yrs.        mos.        ds. In the State        yrs.        mos.        ds.  
Where was disease contracted, if not at place of death?  
Former or usual residence       

19 PLACE OF BURIAL OR REMOVAL Dry Hill DATE OF BURIAL Apr 11, 1915  
20 UNDERTAKER Geo E French ADDRESS Laurel Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

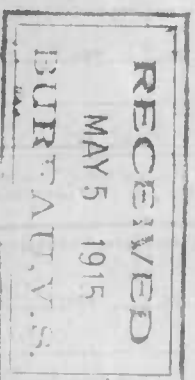
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not painfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scutle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Bruce George  
Village or City Inestville (No. md) St.; Ward  
2 FULL NAME Rebecca M. Cubbin  
STATE OF MARYLAND  
CERTIFICATE OF DEATH  
Registration Dist. No. 236  
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH 15 20, 1885  
(Month) (Day) (Year)

7 AGE 64 yrs. 1 mos. 2 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Housework  
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Daniel Weaver

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward M. Cubbin

(Address) Inestville Md

15 Filed ap 22, 1916 Samuel E. Cox  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 4 22, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from apl 20, 1914, to apl 22, 1915,  
that I last saw her alive on apl 21, 1915,  
and that death occurred on the date stated above, at 3:30 m.

The CAUSE OF DEATH was as follows:

Catastrophic Dysentery  
(Duration) 1 yrs. 0 mos. 0 ds.

Contributory  
Secondary

Paralysis of the bowels  
(Duration) 1 yrs. 0 mos. 0 ds.  
(Signed) John B. Samsbury M. D.  
4-22-15 (Address) Inestville Md

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Forestville Md DATE OF BURIAL ap 22, 1915

20 UNDERTAKER Leah Armstrong ADDRESS Forestville

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

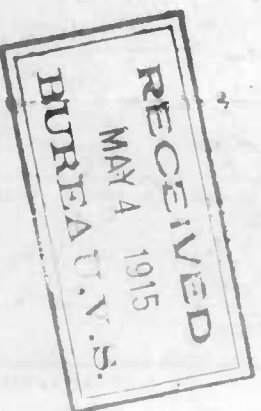
[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Car engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Deputy," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—(tool mine*, etc. Woman at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Meninges*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trama," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Prenatal septichæmia," "Prenatal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS or INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Prince George 5983

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 232

Village or City Leeland Md (No. 189) St.; Ward)

2 FULL NAME Joseph Earl Moore

3 SEX male

4 COLOR OR RACE white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH 2 27 1915  
(Month) (Day) (Year)

7 AGE 1 mos. 6 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Infant  
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md

PARENTS

10 NAME OF FATHER George C Moore

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Heather Kealley

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) George C Moore  
(Address) Leeland Md

15 April 2nd 1915 R Emerson Smith  
Filed REGISTRAR

16 DATE OF DEATH 4 2 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:  
No one attendance  
Supposed Bronchopneumonia  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds.

Contributory  
Secondary  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) John E. Cunningham, M.D.  
Apr 2nd 1915 (Address) Forestville Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State, \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted, If not at place of death?  
Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Leeland Md DATE OF BURIAL April 4, 1915

20 UNDERTAKER Scott Armstrong ADDRESS Upper Marlboro Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

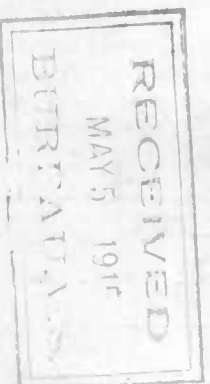
[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Former or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained from the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as *accidental, suicidal*, or *homicidal*, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County

Prince George

Village or City

College Park

(No.

Registration Dist. No.

280

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Cecil Peoli

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

## 6 DATE OF BIRTH

Don't know

(Month)

(Day)

(Year)

## 7 AGE

24

yrs.

mos.

ds.

OR LESS than 1 day, hrs. min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

Aviator

(b) General nature of industry, business, or establishment in which employed (or employer)

Flying machine builder

## 9 BIRTHPLACE

(State or country)

New York

## PARENTS

## 10 NAME OF FATHER

Peoli

## 11 BIRTHPLACE OF FATHER

(State or country)

Don't know

## 12 MAIDEN NAME OF MOTHER

Don't know

## 13 BIRTHPLACE OF MOTHER

(State or country)

Don't know

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. Petreus

(Address)

Coroner's Physician

## 15

Filed

Apr 13th 1915

REGISTRAR

5635

178

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Apr 12

1915

(Month)

(Day)

(Year)

## 17

I HEREBY CERTIFY, That I attended deceased from

1915 to 1915

that I last saw him alive on

April 12

1915

and that death occurred on the date stated above, at.....m.

The CAUSE OF DEATH\* was as follows:

Accident, lost control of flying machine which fell to the ground & was crushed to death

(Duration)

yrs.

mos.

ds.

## Contributory

Secondary

Hemorrhage

(Duration)

yrs.

mos.

ds.

(Signed)

A. Petreus

M. D.

(Address)

Apr 12 1915  
From the disease caused by loss of control of flying machine  
causes, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL Acting Chronic

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs. mos. ds.

In the

State

yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

New York City N.Y.

Apr 14 1915

## 20 UNDERTAKER

## ADDRESS

F. G. S. &amp; Son 1234 Broadway

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

7nd

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on Statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 4 1915  
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

|   |   |   |  |
|---|---|---|--|
| 1 PLACE OF DEATH<br>County <u>Prince Georges</u><br>Village or City <u>Near Forestville</u> (No. <u>5630</u> )  |   | STATE OF MARYLAND<br>CERTIFICATE OF DEATH<br>Registered No. <u>235</u><br>(If death occurred in a hospital or institution, give its NAME instead of street and number.) |  |
| 2 FULL NAME <u>Peter Pope</u>   |   |   |  |
| PERSONAL AND STATISTICAL PARTICULARS  |   |   |  |
| 3 SEX<br><u>Male</u>  | 4 COLOR OR RACE<br><u>White</u>                                   | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br><u>Widowed</u><br>(Write the word)   |  |
| 6 DATE OF BIRTH<br><u>June 10, 1820</u><br>(Month) (Day) (Year)   |   |   |  |
| 7 AGE<br><u>94</u> yrs. <u>4</u> mos. <u>3</u> ds.  |   | If LESS than 1 day, — hrs. OR — min. ?  |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>Carpenter</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) <u>In himself</u>  |   |   |  |
| 9 BIRTHPLACE (State or country) <u>Washington D.C.</u>  |   |   |  |
| PARENTS   | 10 NAME OF FATHER <u>Fredrick Pope</u>                            |   |  |
|   | 11 BIRTHPLACE OF FATHER (State or country) <u>Washington D.C.</u> |   |  |
|   | 12 MAIDEN NAME OF MOTHER <u>Jane Pope</u>                         |   |  |
|   | 13 BIRTHPLACE OF MOTHER (State or country) <u>Washington D.C.</u> |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) _____<br>(Address) _____  |   |   |  |
| 15<br>Filed <u>7-5</u> , 191 <u>5</u> <u>Samuel E. Cox</u><br>REGISTRAR   |   |   |  |
| MEDICAL CERTIFICATE OF DEATH  |   |   |  |
| 16 DATE OF DEATH <u>April 3<sup>rd</sup></u> , 191 <u>5</u><br>(Month) (Day) (Year)   |   |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>April 1</u> , 191 <u>5</u> to <u>April 3<sup>rd</sup></u> , 191 <u>5</u> , that I last saw him alive on <u>April 1</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>3:40 p.m.</u>                         |   |   |  |
| The CAUSE OF DEATH* was as follows:<br><u>Senile Debility</u>   |   |   |  |
| (Duration) _____ yrs. _____ mos. _____ ds.  |   |   |  |
| Contributory (Secondary) <u>Cardiac Exhaustion</u>  |   |   |  |
| (Duration) _____ yrs. _____ mos. _____ ds.  |   |   |  |
| (Signed) <u>Charles M. Commonwealth, M.D.</u><br><u>April 5, 1915</u> (Address) <u>Simland Road</u>   |   |   |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.   |   |   |  |
| 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)<br>At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.<br>Where was disease contracted, if not at place of death? _____<br>Former or usual residence _____ |   |   |  |
| 19 PLACE OF BURIAL OR REMOVAL<br><u>Forestville Md</u>  |   | DATE OF BURIAL<br><u>April 6</u> , 191 <u>5</u>   |  |
| 20 UNDERTAKER<br><u>Thos. McHally</u>   |   | ADDRESS<br><u>Annapolis D.C.</u>  |  |



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia" unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Draemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
MAY 4 1915  
BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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|   |  |  |   |                                   |
|---|--|--|---|-----------------------------------|
| 1 PLACE OF DEATH<br>County <u>Pr. Geo</u>   |  | 5637   | STATE OF MARYLAND<br>CERTIFICATE OF DEATH |                                   |
| Village or City <u>Clinton</u> (No. <u>5</u> )  |  | St.; Ward  |   | Registration Dist. No. <u>238</u> |
| 2 FULL NAME <u>Proctor</u>  |  |  |   |                                   |
| PERSONAL AND STATISTICAL PARTICULARS  |  |  |   |                                   |
| 3 SEX<br><u>Male</u>  | 4 COLOR OR RACE<br><u>Colored</u>                    | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br><u>Single</u><br>(Write the word) |   |                                   |
| 6 DATE OF BIRTH<br><u>Apr 27</u> , 1915<br>(Month) (Day) (Year)   |  |  |   |                                   |
| 7 AGE<br><u>Still Birth</u>   |  | It LESS than 1 day, ____ hrs. ____ yrs. ____ mos. ____ ds. OR ____ min. ?    |   |                                   |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work<br>(b) General nature of industry, business, or establishment in which employed (or employer)   |  |  |   |                                   |
| 9 BIRTHPLACE (State or country) <u>md</u>   |  |  |   |                                   |
| PARENTS   | 10 NAME OF FATHER <u>Joseph Proctor</u>              |  |   |                                   |
|   | 11 BIRTHPLACE OF FATHER (State or country) <u>md</u> |  |   |                                   |
|   | 12 MAIDEN NAME OF MOTHER <u>Mary G. Brown</u>        |  |   |                                   |
|   | 13 BIRTHPLACE OF MOTHER (State or country) <u>md</u> |  |   |                                   |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Joseph Proctor</u><br>(Address) _____  |  |  |   |                                   |
| 15 Filed <u>Apr 28</u> , 1915, <u>Mary W. Thomas</u><br>REGISTRAR   |  |  |   |                                   |
| MEDICAL CERTIFICATE OF DEATH  |  |  |   |                                   |
| 16 DATE OF DEATH <u>Apr 27</u> , 1915<br>(Month) (Day) (Year)   |  |  |   |                                   |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>at time of still birth</u> , 1915, to <u>Apr 27</u> , 1915, that I last saw him alive on <u>before born dead</u> , 1915, and that death occurred on the date stated above, at <u>2 a</u> m. The CAUSE OF DEATH* was as follows:<br><u>Still Birth</u> |  |  |   |                                   |
| (Duration) ____ yrs. ____ mos. ____ ds.   |  |  |   |                                   |
| Contributory<br>Secondary<br>(Duration) ____ yrs. ____ mos. ____ ds.  |  |  |   |                                   |
| (Signed) <u>John A. Cor</u> , M. D.<br><u>Apr 27</u> , 1915 (Address) <u>Pr. Geo</u>  |  |  |   |                                   |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.   |  |  |   |                                   |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.<br>Where was disease contracted, It not at place of death? _____<br>Former or usual residence _____                       |  |  |   |                                   |
| 19 PLACE OF BURIAL OR REMOVAL <u>Clinton md</u> DATE OF BURIAL <u>Apr 28</u> , 1915   |  |  |   |                                   |
| 20 UNDERTAKER <u>Proctor</u> ADDRESS <u>Clinton md</u>  |  |  |   |                                   |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

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[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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BUREAU, V. S.

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## 1 PLACE OF DEATH

County

Pr George

5638

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

240

Village or City

Y.B.

(No.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Boeber

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Colored

5 SINGLE,  
MARRIED,  
WIDOWED,  
ORDIVORCED  
(Write the word)

6 DATE OF BIRTH

Apr 2

(Month)

(Day)

1215

(Year)

7 AGE

Still Birth

If LESS than  
1 day, hrs.  
yrs. mos. ds. OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

Md

## PARENTS

10 NAME OF FATHER

Wm H Boeber

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Mary G. Boeber

13 BIRTHPLACE OF MOTHER

(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm H Boeber

(Address)

Brandyswine Md

15

Filed

Apr 3rd 5 P. Squires

1915

Deputy Local

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Apr 2

1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

1915 to

1915

that I last saw h. alive on 1915

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Still Birth at 8 mo

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

John A Cor

M. D.

Apr 3

1915 (Address)

Brandyswine

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs. mos. ds.

In the

State

yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. John's R.C. Cemetery

Clinton Md.

April 3rd 1915

20 UNDERTAKER

ADDRESS

Eugene Thompson Brandyswine Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

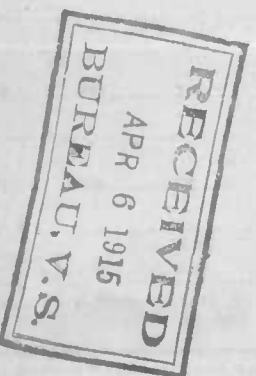
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## 1 PLACE OF DEATH

County

Anne George

5639

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

243

Village or City

Bowie

(No.)

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Joshua Reynolds

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Feb 10, 1890  
(Month) (Day) (Year)

7 AGE

25 yrs 2 mos ds.

If LESS than 1 day, hrs. OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Track Hand on RR

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Washington DC

PARENTS

10 NAME OF FATHER

Peter Reynolds

11 BIRTHPLACE OF FATHER (State or country)

Md

12 MAIDEN NAME OF MOTHER

Rena Duckett

13 BIRTHPLACE OF MOTHER (State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ora Banks

(Address)

Bowie Md

15

Filed

April 10, 1915

1915

Helen Ryan

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 10, 1915  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

, 191, to , 191,

that I last saw h alive on , 191

and that death occurred on the date stated above, at m,

The CAUSE OF DEATH\* was as follows:

Consumption  
tuberculosis of the Lungs

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

John R. White, M.D.

April 10, 1915 (Address) Bowie Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Near Easton, Md. April 15, 1915

20 UNDERTAKER

ADDRESS

Frank Wood Mitchell

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 5 1915

BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

5640

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 248

County Prince GeorgesVillage or City Mt. Rainier (No. \_\_\_\_\_)

St.; \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Andrew Jackson Riley

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)married

6 DATE OF BIRTH

Sept 1

(Month)

(Day)

1848  
(Year)

7 AGE

67 yrs. 7 mos. 8 ds.If LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Farmers

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Va

10 NAME OF FATHER

Jacob Riley

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary Hicks

13 BIRTHPLACE OF MOTHER

(State or country)

Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Emma Riley

(Address)

Mt Rainier Md

15

Filed

April 9, 1915 J. C. Oshendor

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Apr 8

(Month)

(Day)

1915  
(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 201915

to

Apr 81915that I last saw him alive on Apr 6, 1915and that death occurred on the date stated above, at 11 A m.

The CAUSE OF DEATH\* was as follows:

Enteritis and diarrhoea(Duration) \_\_\_\_ yrs. 3 mos. \_\_\_\_ ds.Contributory  
SecondaryExhaustion(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 21 ds.

(Signed)

R. W. Conklin

, M. D.

Apr 91915

(Address)

20 S. P. St. N.E.

\*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the

State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted,  
If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bladensburg MdApr 10, 1915

20 UNDERTAKER

ADDRESS

St. Gaspar's Sons BladensburgMd

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or misarrriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
MAY 4 1915  
BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Prince George

Village or City

Berwyn

(No.)

Registration Dist. No.

230

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

—

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

Apr 21, 1915  
(Month) (Day) (Year)

7 AGE

1 day, 1 hrs.  
yrs. mos. ds. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md

PARENTS

10 NAME OF FATHER

Chas W. Sanford

11 BIRTHPLACE OF FATHER (State or country)

Wash. DC.

12 MAIDEN NAME OF MOTHER

Sarah E. Perry

13 BIRTHPLACE OF MOTHER (State or country)

Wash. DC.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. P. Turner

(Address)

Berwyn

15

Filed

May 3rd, 1915 - John D. Smith

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Apr 21, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Apr 21, 1915, to —, 1915

that I last saw him alive on —, 1915

and that death occurred on the date stated above, at 5:00 p.m.

The CAUSE OF DEATH\* was as follows:

Miscarriage 4th Month

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

J. P. Turner

M. D.

Apr 22, 1915 (Address) Berwyn

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preserved in alcohol, 1915

20 UNDERTAKER

ADDRESS



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

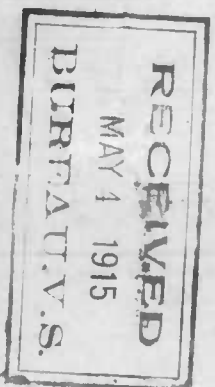
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Princess George's

Village or City

Riverdale

(No.)

St.:

Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

231

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Joseph Schoenbauer

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

Feb

25

1915

(Month)

(Day)

(Year)

7 AGE

5

yrs.

2

mos.

ds.

If LESS than  
1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md

## PARENTS

10 NAME OF FATHER

Frank Schoenbauer

11 BIRTHPLACE OF FATHER

(State or country)

Bohemian

12 MAIDEN NAME OF MOTHER

Minnie Miller

13 BIRTHPLACE OF MOTHER

(State or country)

Bohemian

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Schoenbauer

(Address)

Hyallsville Md

15

Filed

Apr 27, 1915

M. D. Spicer

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Apr 25

1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Feb 25

1915

to

Apr 25

1915

that I last saw him alive on

Apr 25

1915

and that death occurred on the date stated above, at 1:00 m.

The CAUSE OF DEATH\* was as follows:

Inflammation

(Duration)

yrs. 1

mos.

ds.

Contributory  
Secondary

(Duration)

yrs. 1

mos.

ds.

(Signed)

H. J. Willis

M. D.

(Address)

Hyallsville Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bladensburg Md

Apr 27, 1915

20 UNDERTAKER

ADDRESS

F. G. Goolsby Sons Bladensburg Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

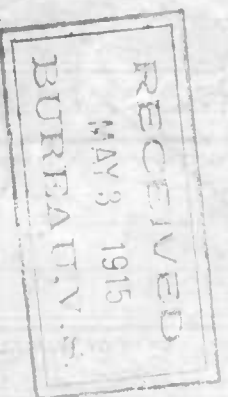
[Approved by U. S. Census and American Public Health Association.]

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*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicaemia," "Puerperal, peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Prince George

Village or City Thimonsville Heights No. 10 St.; Ward)

2 FULL NAME Alice Roberta Silence

Registration Dist. No. 247

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH July 14, 1851  
(Month) (Day) (Year)

7 AGE 64 yrs. 1 mos. 26 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Unemployed  
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER John P. Silence

11 BIRTHPLACE OF FATHER (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Caroline A. Butler

13 BIRTHPLACE OF MOTHER (State or country) West Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Eugene L. Silence  
(Address) Thimonsville Heights, Md.

15 Filed April 10, 1915 John E. Warrick  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 9, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1915, to April 9, 1915, that I last saw her alive on April 9, 1915, and that death occurred on the date stated above, at 8:40 P.

The CAUSE OF DEATH was as follows:

Pneumonia  
(Duration) yrs. mos. 3 ds.

Contributory La Grippe  
Secondary

(Signed) J. H. Warrick M. O.  
April 10, 1915 (Address) 44 N. W. Corbett St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death yrs. mos. ds. In the State, yrs. mos. ds.  
Where was disease contracted,  
If not at place of death?  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. C. Harmony Cemetery DATE OF BURIAL April 12, 1915

20 UNDERTAKER R. L. McGehee ADDRESS 824 Thacker Ave.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plowman*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Tricory*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*gus, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mosquito*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mosquito* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 3 1915  
BUREAU, V.S.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1 PLACE OF DEATH<br>County <u>Pr George</u>  |   | 5644  |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH   |  |
| Village or City <u>Bowie</u>   |   | (No. <u>74d</u> )   |  | Registration Dist. No. <u>243</u>   |  |
| 2 FULL NAME <u>Iron V Stewart</u>  |   |   |  | [If death occurred in a hospital or institution, give its NAME instead of street and number.] |  |
| PERSONAL AND STATISTICAL PARTICULARS   |   |   |  |   |  |
| 3 SEX<br><u>Male</u>   | 4 COLOR OR RACE<br><u>colord</u>  | 5 SINGLE, MARRIED, WIDDED OR DIVORCED<br>(Write the word) |  |   |  |
| 6 DATE OF BIRTH<br><u>July 7, 1915</u><br>(Month) (Day) (Year)   |   |   |  |   |  |
| 7 AGE<br><u>3 yrs. 3 mos. 12 ds.</u>   |   | If LESS than 1 day, hrs. OR min. ?                        |  |   |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work<br><u>none</u><br>(b) General nature of industry, business, or establishment in which employed (or employer)<br><u>none</u>  |   |   |  |   |  |
| 9 BIRTHPLACE<br>(State or country)<br><u>Bowie Md</u>  |   |   |  |   |  |
| PARENTS  | 10 NAME OF FATHER<br><u>Beng. D Stewart</u>                             |   |  |   |  |
|  | 11 BIRTHPLACE OF FATHER<br>(State or country)<br><u>Pr Geo Co Md</u>    |   |  |   |  |
|  | 12 MAIDEN NAME OF MOTHER<br><u>Mary E Johnson</u>                       |   |  |   |  |
|  | 13 BIRTHPLACE OF MOTHER<br>(State or country)<br><u>Pr George Co Md</u> |   |  |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE   |   |   |  |   |  |
| (Informant) <u>Beng D Stewart</u>  |   |   |  |   |  |
| (Address) <u>Bowie Md</u>  |   |   |  |   |  |
| 15 Filed <u>April 19, 1915</u> <u>Wm A Ryan</u> REGISTRAR  |   |   |  |   |  |
| MEDICAL CERTIFICATE OF DEATH   |   |   |  |   |  |
| 16 DATE OF DEATH<br><u>April 19, 1915</u><br>(Month) (Day) (Year)  |   |   |  |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>March 5th</u> , 1915, to <u>April 11</u> , 1915, that I last saw him alive on <u>April 11</u> , 1915, and that death occurred on the date stated above, at <u>6 am</u> . The CAUSE OF DEATH * was as follows:<br><u>Marasmus</u> |   |   |  |   |  |
| Contributory <u>Heart Failure</u><br>(Duration) yrs. <u>1</u> mos. <u>21</u> ds.   |   |   |  |   |  |
| (Signed) <u>James H. Pruitt</u><br><u>April 19, 1915</u> (Address) <u>Bowie Md.</u>  |   |   |  |   |  |
| * State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.  |   |   |  |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death yrs. mos. ds. In the State, yrs. mos. ds.<br>Where was disease contracted, If not at place of death?<br>Former or usual residence   |   |   |  |   |  |
| 19 PLACE OF BURIAL OR REMOVAL<br><u>Deasant Gov. Bowie Md</u>  |   |   |  | DATE OF BURIAL<br><u>April 31, 1915</u>   |  |
| 20 UNDERTAKER<br><u>M. Fladerng Sons</u>   |   |   |  | ADDRESS<br><u>Collington Md</u>   |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

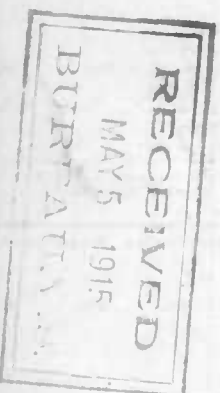
[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic nodular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trismus," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *telanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Pr George

Village or City Bowie (No. MD St. Ward)

2 FULL NAME Mary E Stewart

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 243

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Caucasian 5 ~~SINGLE~~ MARRIED WIDOWED OR DIVORCED (Write this word)

6 DATE OF BIRTH (Month) (Day) (Year) 1

7 AGE 41 yrs. 4 mos. 0 ds. If LESS than 1 day, 0 hrs. OR 0 min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Housework (b) General nature of industry business, or establishment in which employed (or employer) Housework

9 BIRTHPLACE (State or country) Pr Geo Co MD

10 NAME OF FATHER Thomas Johnson

11 BIRTHPLACE OF FATHER (State or country) Pr Geo Co MD

12 MAIDEN NAME OF MOTHER \_\_\_\_\_

13 BIRTHPLACE OF MOTHER (State or country) Pr Geo Co MD

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Benny Stewart (Address) Bowie MD

15 Filed April 12, 1915 Nelson Byron MD REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 11, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from March 20, 1915, to April 11, 1915;

that I last saw her alive on April 11, 1915, and that death occurred on the date stated above, at 12 A.M.

The CAUSE OF DEATH was as follows:

Heart Failure caused by tuberculosis (Duration) 3 yrs. 0 mos. 0 ds.

Contributory Heart Failure Secondary + tuberculosis (Duration) 1 yrs. 0 mos. 0 ds.

(Signed) James H. Smith M. D. April 12, 1915 (Address) Bowie MD

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State, 0 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Heasant Goss, Bowie MD DATE OF BURIAL April 13, 1915

20 UNDERTAKER M. Shading Sons ADDRESS Collington MD

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc.; *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmition," "Marasmus," "Old Age," "Shock," "Typhnia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *telonies*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 5 1915  
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Prima George

Village or City

New Collington

(No. ....)

Registration Dist. No.

238

St.; .... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

William L. Stewart

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

Feb 27

1852

(Month)

(Day)

(Year)

7 AGE

48

yrs.

1

mos.

8

ds.

If LESS than  
1 day, .... hrs.  
OR .... min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work

Farmer

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)9 BIRTHPLACE  
(State or country)

Prima George Co. Md.

PARENTS

10 NAME OF  
FATHER

David Knowles

11 BIRTHPLACE  
OF FATHER  
(State or country)

Not Known

12 MAIDEN NAME  
OF MOTHER

Eliza Hooker

13 BIRTHPLACE  
OF MOTHER  
(State or country)

Not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas Bayler

(Address)

Metairie Md.

15

Filed

, 191

REGISTRAR

5645

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 5

1912

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

March 12, 1912, to April 5, 1912.

that I last saw him alive on April 5, 1912.

and that death occurred on the date stated above, at 12 m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

not known

(Duration) .... yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) .... yrs. .... mos. .... ds.

(Signed)

J. M. Duvall

, M. D.

, 191 (Address) Springfield Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted,

If not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

White Marsh

April 8, 1912

20 UNDERTAKER

ADDRESS

Frank Wood

Metairie Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 6 1915

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Prince George's  
Village or City Lanham (No. \_\_\_\_\_) St.; \_\_\_\_\_ Ward \_\_\_\_\_  
2 FULL NAME Mona S. Suter

STATE OF MARYLAND  
CERTIFICATE OF DEATH  
Registration Dist. No. 239

(It death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH May 26, 1863  
(Month) (Day) (Year)

7 AGE 51 yrs. 11 mos. 21 ds. If LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Stanton

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Amelia Boswell

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Samuel E. Suter  
(Address) Lanham Md

15 Filed Apr. 5th 1915 Wm. A. Fairall  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 8, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1915, to April 8, 1915, that I last saw him alive on April 8, 1915, and that death occurred on the date stated above, at 4:20 P. m. The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 8 ds.

Contributory (Secondary) \_\_\_\_\_  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Doyle Jones, M. D.  
April 8, 1915 (Address) Lanham

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Where was disease contracted, If not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Low Hill DATE OF BURIAL April 7th 1915

20 UNDERTAKER E. O. French ADDRESS Lanham Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—(oil mill, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 5 1915

BUTLER COUNTY, PA.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Prince George  
Village or City Murkirk (No. 151) St.; ..... Ward)  
2 FULL NAME Jennie Thomas  
Registration Dist. No. 239  
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single  
6 DATE OF BIRTH April 17, 1915 (Month) (Day) (Year)  
7 AGE ..... yrs. .... mos. 3 ds. If LESS than 1 day, .... hrs. OR .... min. ?  
8 OCCUPATION  
(a) Trade, profession, or particular kind of work None  
(b) General nature of industry business, or establishment in which employed (or employer) None

## 9 BIRTHPLACE (State or country)

## PARENTS

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (State or country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Apr. 16<sup>th</sup>, 1915 Wm. A. Fairall  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Apr 15, 1915  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

Apr 15, 1915, to Apr 15, 1915that I last saw him alive on Apr 15, 1915and that death occurred on the date stated above, at 4 p. m.

The CAUSE OF DEATH \* was as follows:

Infantile measles  
(Duration) ..... yrs. .... mos. .... ds.Contributory  
Secondary(Signed) J. R. Smith  
Apr 16, 1915 (Address) London  
\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. .... mos. .... ds. In the State, ..... yrs. .... mos. .... ds.  
Where was disease contracted, If not at place of death ?  
Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Murkirk April 17<sup>th</sup>, 1915

## 20 UNDERTAKER

## ADDRESS

Geo. C. French London Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plowman*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Sphew*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Driver," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Meadles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Meadles* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Ashtemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Hantion," "Marasmus," "Old Age," "Shock," "Tranema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Prenatal *septicarmito*," "Prenatal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as *accidental*, *suicidal*, or *homicidal*, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by cathartic oil—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

MAY 5 1915

BUREAU, V.S.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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|  |  |                                 |                           |  |  |   |  |  |
|--|--|---------------------------------|---------------------------|--|--|---|--|--|
| 1 PLACE OF DEATH<br>County <u>unknown</u>  |  |                                 | 5648 (184) <del>104</del> |  |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH |  |  |
| Village or City <u>unknown</u>   |  |                                 | St.; Ward)                |  |  | Registration Dist. No. <u>247</u>         |  |  |
| 2 FULL NAME <u>unknown</u>   |  |                                 |                           |  |  |   |  |  |
| PERSONAL AND STATISTICAL PARTICULARS   |  |                                 |                           |  |  |   |  |  |
| 3 SEX<br><u>female</u>   |  | 4 COLOR OR RACE<br><u>white</u> |                           | 5 SINGLE, MARRIED, WIDOWED OR DIVORCED<br>(Write the word) <u>infant</u> |  |   |  |  |
| 6 DATE OF BIRTH<br><u>unknown</u> , 1 (Month) (Day) (Year)   |  |                                 |                           |  |  |   |  |  |
| 7 AGE<br><u>supposed</u> yrs. mos. ds.   |  |                                 |                           | If LESS than 1 day; hrs. OR min.?  |  |   |  |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work<br>(b) General nature of industry, business, or establishment in which employed (or employer)  |  |                                 |                           |  |  |   |  |  |
| 9 BIRTHPLACE<br>(State or country) <u>unknown</u>  |  |                                 |                           |  |  |   |  |  |
| PARENTS  | 10 NAME OF FATHER <u>unknown</u>                             |                                 |                           |  |  |   |  |  |
|  | 11 BIRTHPLACE OF FATHER<br>(State or country) <u>unknown</u> |                                 |                           |  |  |   |  |  |
|  | 12 MAIDEN NAME OF MOTHER <u>unknown</u>                      |                                 |                           |  |  |   |  |  |
|  | 13 BIRTHPLACE OF MOTHER<br>(State or country) <u>unknown</u> |                                 |                           |  |  |   |  |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE   |  |                                 |                           |  |  |   |  |  |
| (Informant) <u>John E. Wroth acting coroner</u>  |  |                                 |                           |  |  |   |  |  |
| (Address) <u>Capitol Heights and</u>   |  |                                 |                           |  |  |   |  |  |
| 15 Filed <u>April 25</u> , 1915 <u>John E. Wroth</u> REGISTRAR   |  |                                 |                           |  |  |   |  |  |
| MEDICAL CERTIFICATE OF DEATH   |  |                                 |                           |  |  |   |  |  |
| 16 DATE OF DEATH <u>unknown</u> , 1915 (Month) (Day) (Year)  |  |                                 |                           |  |  |   |  |  |
| 17 I HEREBY CERTIFY, That I attended deceased from , 191 , to , 191 , that I last saw h alive on , 191 , and that death occurred on the date stated above, at m. The CAUSE OF DEATH * was as follows:  |  |                                 |                           |  |  |   |  |  |
| <u>Found dead in pond</u><br><u>supposed to have been husband</u><br><u>autopsy performed at</u><br><u>St. Joseph's</u><br><u>Contributory</u><br><u>Secondary</u><br><u>John E. Wroth</u> (Signed) <u>April 25</u> , 1915 (Address) <u>Frostville Md</u><br>* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL. |  |                                 |                           |  |  |   |  |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  |  |                                 |                           |  |  |   |  |  |
| At place of death yrs. mos. ds. In the State, yrs. mos. ds.  |  |                                 |                           |  |  |   |  |  |
| Where was disease contracted, If not at place of death?  |  |                                 |                           |  |  |   |  |  |
| Former or usual residence  |  |                                 |                           |  |  |   |  |  |
| 19 PLACE OF BURIAL OR REMOVAL <u>Frostville and</u>  |  |                                 |                           |  |  | DATE OF BURIAL <u>April 26</u> , 1915     |  |  |
| 20 UNDERTAKER <u>George W. Roberts</u> constable   |  |                                 |                           |  |  | ADDRESS <u>Maryland Park</u>              |  |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Woolery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Teacher," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name organ); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tramia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Prenatal septicemia," "Prenatal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 3 1915  
BUREAU, V

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

2 FULL NAME

5649

(No.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day, hrs.  
OR, min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work

(b) General nature of industry  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

, 191

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH \* was as follows:

Contributory

Secondary

(Signed)

April 9, 1915 (Address)

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place

of death

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Coal engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reinier wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *telanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

MAY 6 1915

BUREAU U. S. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County

Prince George's County

5650

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 247

Village or City

Capitol Heights (No. 14212 Ave. S. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Benedict Noble Ward

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED

married

6 DATE OF BIRTH

ap 14

(Month)

(Day)

1885 (Year)

7 AGE

30

yrs.

0

mos.

0

ds.

If LESS than 1 day, hrs. OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Paperhanger

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Prince George's Co., Md

10 NAME OF FATHER

John Ward

11 BIRTHPLACE OF FATHER

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mannis Ward

13 BIRTHPLACE OF MOTHER

(State or country)

Wash D.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Evelyn Jacobs

(Address)

Capitol Heights Md

15

Filed

April 17, 1915

Grace Snow

Deputy Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

april 14

(Month)

(Day)

1915 (Year)

17

I HEREBY CERTIFY, That I attended deceased from

ap 5

1915, to

ap 14

1915,

that I last saw him alive on April 13, 1915,

and that death occurred on the date stated above, at 12:10 AM

The CAUSE OF DEATH was as follows:

Bronchopneumonia

(Duration) 0 yrs. 0 mos. 7 ds.

Contributory

Pulmonary

Secondary

tuberculosis

(Duration) 0 yrs. 0 mos. 21 ds.

(Signed)

Robert B. Bacon M. D.

April 14, 1915

(Address)

631 Md Ave N.E.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State,

yrs.

mos.

ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Addison Chapel Md

April 17, 1915

20 UNDERTAKER

Wm H. Sardo &amp; Co

ADDRESS

408 - 4th N.E.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
MAY 3 1915  
BUREAU, V. S.

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## 1 PLACE OF DEATH

County

Prince George

Village or City

Beltsville

(No.)

St.; Ward)

## 2 FULL NAME

not named (Widow)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 230

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Caucasian

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

infant

6 DATE OF BIRTH

April 13

(Month)

(Day)

(Year)

7 AGE

one day

If LESS than

1 day, hrs.

yrs.

mos.

ds.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

John A. Heintz

11 BIRTHPLACE OF FATHER

(State or country)

Prince Georges

12 MAIDEN NAME OF MOTHER

Clara I. Smith

13 BIRTHPLACE OF MOTHER

(State or country)

Montgomery Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Heintz

(Address)

Beltsville

15

Filed

Apr 16th 1915 John Smith

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 15

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

April 13, 1915 to April 14, 1915

that I last saw him alive on April 14, 1915

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

5-months birth well &amp;c

(Duration) yrs. mos. ds.

Contributory Secondary

as stated above

(Duration) yrs. mos. ds.

(Signed)

C. A. Fox

M. D.

1915 (Address)

Beltsville Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

1 yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

Grave

DATE OF BURIAL

17 Apr 1915

20 UNDERTAKER

No undertaker

ADDRESS

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[Approved by U. S. Census and American Public Health Association.]

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*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County

*B. George*

Village or City

*Clinton*

(No.)

Registration Dist. No.

*238*

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

*Elizabeth White*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*5 SINGLE, MARRIED, WIDOWED, OR DIVORCED  
(Write the word)*Widow*

6 DATE OF BIRTH

*Not known*

(Month)

(Day)

(Year)

7 AGE

*about -**70*

yrs.

mos.

ds.

If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

*Mo*

## PARENTS

10 NAME OF FATHER

*Warren White*11 BIRTHPLACE OF FATHER  
(State or country)*Mo*

12 MAIDEN NAME OF MOTHER

*Elizabeth Wheat*13 BIRTHPLACE OF MOTHER  
(State or country)*Mo*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Berj White*

(Address)

*Clinton*

15

Filed

*Apr 17, 1915 Mary W. Thomas*

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Apr**16**1915*

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

*Apr 11*

1915 to

*Apr 16*

1915

that I last saw him alive on *Apr 15*, 1915and that death occurred on the date stated above, at *6:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Snuff & Bronchitis*

(Duration)

yrs.

mos.

ds.

Contributory

Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

*John A. Coe*

M. D.

*Apr 13*

1915 (Address)

*Brandywine*

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

It not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Clinton Md**Apr 18, 1915*

20 UNDERTAKER

ADDRESS

*Scott Armstrong**Upper Marlboro Md*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

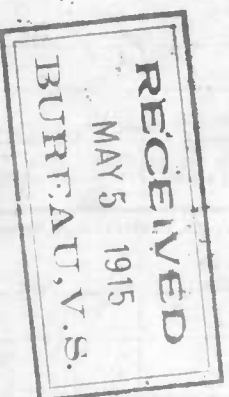
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*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
MAY 4 1915  
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Pr. Geo's  
Village or City Aguassee (No. 151) St.; Ward  
2 FULL NAME unnamed Wilkerson

Registration Dist. No. 237

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Apr 25, 1915  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Ind

PARENTS  
10 NAME OF FATHER Nathan Wilkerson  
11 BIRTHPLACE OF FATHER (State or country) Chas Co Ind  
12 MAIDEN NAME OF MOTHER Princess Wilkerson  
13 BIRTHPLACE OF MOTHER (State or country) Chas Co Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Nathan Wilkerson  
(Address) Aguassee Ind

15 Filed \_\_\_\_\_, 191\_\_\_\_

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 25, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr 25, 1915, to Apr 25, 1915

that I last saw her alive on Apr 25, 1915

and that death occurred on the date stated above, at 11 P. m.

The CAUSE OF DEATH\* was as follows:  
Premature Birth

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (Secondary) Frailty of mother

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) N. Wilkerson, M. D.

Apr 26, 1915 (Address) Aguassee

\*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Chas Co Ind Apr 26, 1915

20 UNDERTAKER ADDRESS

N. J. Quinn Aguassee Ind

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

MAY 4 1915

BUREAU U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| 1 PLACE OF DEATH   |   |   | 5655  |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH   |  |
|--|---|---|---|--|---|--|
| County <u>B. Geo. County</u>   |   |   |  |  | Registration Dist. No. <u>23</u>  |  |
| Village or City <u>Upper Marlboro</u> (No. ....) St.; .... Ward  |   |   |   |  | [If death occurred in a hospital or institution, give its NAME instead of street and number.] |  |
| 2 FULL NAME <u>James H. W. Wilson</u>  |   |   |   |  |   |  |
| PERSONAL AND STATISTICAL PARTICULARS   |   |   |   |  |   |  |
| 3 SEX<br><u>Male</u>   | 4 COLOR OR RACE<br><u>White</u>                                     | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br><u>Married</u><br>(Write the word) |   |  |   |  |
| 6 DATE OF BIRTH <u>Dec 9</u> , 18 <u>30</u><br>(Month) (Day) (Year)  |   |   |   |  |   |  |
| 7 AGE <u>79</u> yrs. <u>4</u> mos. <u>4</u> ds. OR <u>1</u> day, .... hrs. <u>1</u> min. ?   |   |   |   |  |   |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>Dep't Clerk, C. C.</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u>   |   |   |   |  |   |  |
| 9 BIRTHPLACE (State or country) <u>B. Geo. County Md</u>   |   |   |   |  |   |  |
| PARENTS  | 10 NAME OF FATHER <u>Harold B. Wilson</u>                           |   |   |  |   |  |
|  | 11 BIRTHPLACE OF FATHER (State or country) <u>B. Geo. County Md</u> |   |   |  |   |  |
|  | 12 MAIDEN NAME OF MOTHER <u>Elizabeth A. Wall</u>                   |   |   |  |   |  |
|  | 13 BIRTHPLACE OF MOTHER (State or country) <u>B. Geo. Co Md</u>     |   |   |  |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Lavinia M. B. Smith</u><br>(Address) <u>Upper Marlboro</u>  |   |   |   |  |   |  |
| 15 Filed <u>April 12, 1915</u> <u>R. E. Smith</u><br>REGISTRAR   |   |   |   |  |   |  |
| MEDICAL CERTIFICATE OF DEATH   |   |   |   |  |   |  |
| 16 DATE OF DEATH <u>Apr. 9</u> , 191 <u>5</u><br>(Month) (Day) (Year)  |   |   |   |  |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Apr 9</u> , 191 <u>5</u> , to <u>Apr 9</u> , 191 <u>5</u> , that I last saw him alive on <u>Apr 9</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>8 P</u> m. The CAUSE OF DEATH* was as follows:<br><u>Chronic Valvular Disease of Heart</u><br>(Duration) .... yrs. .... mos. .... ds. |   |   |   |  |   |  |
| Contributory<br>Secondary<br>(Signed) <u>L. A. Giffels</u> , M. D.<br><u>Apr 12, 1915</u> (Address) <u>Upper Marlboro</u>  |   |   |   |  |   |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  |   |   |   |  |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.<br>Where was disease contracted, If not at place of death? ....<br>Former or usual residence. ....   |   |   |   |  |   |  |
| 19 PLACE OF BURIAL OR REMOVAL <u>Upper Marlboro Md</u> DATE OF BURIAL <u>April 12, 1915</u>  |   |   |   |  |   |  |
| 20 UNDERTAKER <u>Scott Armstrong</u> ADDRESS <u>Upper Marlboro</u>   |   |   |   |  |   |  |



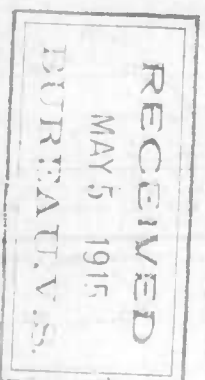
# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County

Prince George's

Village or City

Upper Marlboro (No.

Registration Dist. No. 232

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Wyrill

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

April 19, 1915

7 AGE

Still Born

If LESS than 1 day, hrs. yrs. mos. ds. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Maryland

PARENTS

10 NAME OF FATHER

Samuel A. Wyrill

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Barbara Estelle Schut

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Samuel A. Wyrill

(Address)

Upper Marlboro Md.

15

Filed

April 19, 1915 R. E. Smith

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 19, 1915

17

I HEREBY CERTIFY, That I attended deceased from

1915, to 1915

that I last saw him alive on 1915

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Still born

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

D. A. Griffith

M. D.

Apr 19, 1915 (Address) Upper Marlboro

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Upper Marlboro Md April 20, 1915

20 UNDERTAKER

ADDRESS

Samuel A. Wyrill Upper Marlboro Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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